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Official Report of Debates (Hansard)

Monday 21 November 2016

Journal des débats (Hansard)

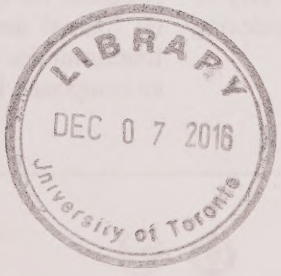
Lundi 21 novembre 2016

Standing Committee on the Legislative Assembly

Comité permanent de l'Assemblée législative

Patients First Act, 2016

Loi de 2016 donnant
la priorité aux patients



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Monday 21 November 2016

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON THE LEGISLATIVE ASSEMBLY

COMITÉ PERMANENT DE L'ASSEMBLÉE LÉGISLATIVE

Monday 21 November 2016

Lundi 21 novembre 2016

The committee met at 0902 in committee room 1.

PATIENTS FIRST ACT, 2016
LOI DE 2016 DONNANT LA PRIORITÉ AUX PATIENTS

Consideration of the following bill:

Bill 41, An Act to amend various Acts in the interests of patient-centred care / Projet de loi 41, Loi modifiant diverses lois dans l'intérêt des soins axés sur les patients.

The Chair (Mr. Monte McNaughton): Good morning, everyone. Welcome to the Standing Committee on the Legislative Assembly. We're here for another day of public hearings on Bill 41, An Act to amend various Acts in the interests of patient-centred care.

ASSOCIATION OF FAMILY HEALTH TEAMS OF ONTARIO

The Chair (Mr. Monte McNaughton): The first presenter this morning is the Association of Family Health Teams of Ontario. If you'd come forward and read your name for Hansard, please. You have nine minutes for your presentation, followed by two minutes of questioning from each party.

I would remind the committee members who are here that we only have two minutes for questions, so try to keep them short so the presenters can give an answer.

Begin when you're ready.

Ms. Angie Heydon: Thank you for the opportunity. My name is Angie Heydon. I am the CEO of the Association of Family Health Teams of Ontario. I am here with Kavita Mehta, who, in a week and a half, will be taking over as the CEO of the association.

Just very briefly, for those who may not be familiar: This is an association whose vision is all about promoting high-quality, comprehensive, interprofessional primary care for all Ontarians. Our membership at this point in time includes virtually all of the family health teams in the province, as well as quite a number of nurse practitioner-led clinics.

You've received our print submission. Our perspective is really based on the fact that evidence has proven that a strong health system that delivers good patient outcomes, is economically viable and has that sustainability is built on a strong foundation of primary care. What is it about primary care that makes that so? It's the ability to wrap care around people as persons and bring all of those different elements together.

With that said, the first point we want to make is that Bill 41 does need to go forward. There are some excellent elements within that bill that will strengthen our health system because they're built on strengthening that foundation of primary care. What it does is that it enables primary care to come to the table with all of the other health care providers. They've been left out of the previous LHIN act. They put forward a mechanism called—well, I'm not quite sure what it's called at the moment, but the regions within LHINs that, at the community level, can plan for a population as a whole and bring those providers together.

It also has the object to improve health equity. If we're going to talk about populations and the health of Ontarians, we have to address equity.

Finally, it creates an enabling step, which is the dissolution of community care access centres.

There are three points that we'd like to make about, if I can call them, enhancements to Bill 41—the parts where it just needs to go a bit further.

The first of these, again, is about wrapping care around people. Dissolving CCACs and going to the LHINs is a first step. It's a transitional step. We understand that there is the need to do that. It has to go further, though. Care coordination must be a fundamental, integrated part of primary care. In the appendix to our paper, we give a case study example of what the difference for people would look like. It's to make care better.

There's also another key issue here, in that LHINs cannot be involved in service delivery or it puts them directly in a conflict of interest. There was a previous government of this province, in the early 2000s, that actually said to Cancer Care Ontario, "You cannot steer and row at the same time." In the early 2000s, Cancer Care Ontario was required to divest its direct service delivery operations to hospitals and communities, and it concentrated on quality planning and funding to improve the outcomes for patients. Look at what a difference it made. We went from, around 2000, having to ship patients to the US because we couldn't care for them in Ontario, and now we have a very high-performing cancer system. Once again, LHINs should not be in the service delivery business or they'll be in conflict.

The second point that we are making is that we need to have that strong leadership and stewardship in the

system to make sure that there are checks and balances that avoid unilateral action. We note that there is a requirement for the minister to deliver a strategic plan, according to the LHIN act. That was in 2006. We still don't have such a thing. That needs to be strengthened to make that come forward because, with a clear vision and strategy for the health system, then we have a context for what "in the public interest" means, and therefore decisions can be made in that context if remedial action such as investigators, supervisors etc. need to be put in place. So we just note some amendments that could be made to make sure those checks and balances are there.

The final point that we make is that the health system is built on collaboration; there are no two ways around that. Collaboration requires trusting relationships. If we look at the world we inhabit—interprofessional primary care—that is the epitome of trusting, collaborative relationships. Many people, when they think of a family health team, think of it as an entity. It's actually two separate entities. It's actually one entity called a family health team, which is the mechanism with a board that hires all the other different professions—physicians are still independent of that family health team.

So the fact that we have all of these teams working so well together is because, voluntarily, they're collaborating to improve care, because they share a vision: We want to give the best care possible. The concern is—and I know that has been pointed out by a number of the physician groups—that it's seen as the potential, at least, for the act, by requiring family health teams to meet accountability requirements and so on—that that could be a backdoor way of making physicians accountable, and that has the potential to drive physicians away from teams rather than attract them to the model that evidence tells us is the best way to care for people.

All we're asking for is—we're not saying, "Don't do it." We're saying to put an amendment into the bill that allows that provision of bringing all of the different interprofessional teams under the LHIN umbrella, to be proclaimed at a later date by Lieutenant Governor in Council, because there is very important work that's needed to be done to develop a stronger environment of trust and collaboration within the health system to make this go forward.

In sum, we're very much in support of the bill. We recognize that, in implementation, there are many details that we're working through, but we do have those suggestions for improvement.

0910

The Chair (Mr. Monte McNaughton): Thank you very much. We'll move to the official opposition and Mr. Yurek.

Mr. Jeff Yurek: Good morning. Thanks for coming in today and for providing your synopsis of the bill and your ideas and amendments. We'll definitely take them forward in considering amendments to the bill in another couple of weeks.

It seems to me, looking over this, that the current environment in the health care sector is going to make this transition a little more difficult than it really needs to be. Do you have any thoughts on that?

Ms. Angie Heydon: Just the thought that there's so much that can be done in a collaborative way that the bill actually enables. That's the reason why we are making that recommendation to just hold back to a later date for proclaiming the piece about primary care—so that the concerns that are currently held in this system can be addressed and dealt with.

Mr. Jeff Yurek: Just to reiterate: You also have concerns about the LHINs providing services. You think they should be more hands-off from the service delivery part of that?

Ms. Angie Heydon: The function that they currently hold, which is planning, funding, evaluating—that is a really important role. I drew the analogy to Cancer Care Ontario's role in the health system, as well. They need to keep that arm's length so that they can do that role fully. As soon as they get involved in service delivery, they have to evaluate themselves. It's a conflict.

The Chair (Mr. Monte McNaughton): Ms. Armstrong?

Ms. Teresa J. Armstrong: First, I want to say thank you very much for coming in today. I think your perspective is very important to this bill and the changes that are going to be coming forward in health care.

Did you feel the government fully consulted you before drafting this bill—from your concern with regard to asking about a later date for the health teams, with the Lieutenant Governor proposition?

Ms. Angie Heydon: Actually, we had plenty of consultation with government, so that's not a concern at all. The issues that we have flagged are issues that have developed over the last number of months. We're saying very specifically that physicians are up in arms at the moment. Given the collaborative environment in which our members work and the need to bring more physicians—not just the physicians who are working in teams right now, but the physicians who are working in the community—to work with the interprofessional providers in teams, is that—we can't do that if there's not trust in the system.

Ms. Teresa J. Armstrong: Do you think the government is listening to your proposal for it to be put off for a while? And if that doesn't happen, how do you see that adversely affecting what you're describing today?

Ms. Angie Heydon: So much of this is about implementation and how implementation goes forward. Right at this moment, I think most people are still in the positive—"Let's work together. Let's figure these things out." So I think the intents are there. I can't speak for government, obviously.

The Chair (Mr. Monte McNaughton): We'll move to the government. Ms. Kiwala.

Ms. Sophie Kiwala: Thank you, Angie, for coming in. I know it probably took something to get here today, as it did for all of us; hence, our short numbers.

Welcome, Kavita, as well, in your new role. We look forward to working with you in the future.

I was inspired by your communication this morning and particularly your comments on the wraparound care for people as persons. I think that's certainly something that the government is very focused on doing. We're very pleased to be working with a model with that as a mission.

I wanted to ask you a little bit about some of the transformational opportunities that you see going forward and how you feel they will benefit the health care system.

Ms. Angie Heydon: By bringing together people working at the sub-regional level, there is that opportunity to bring together all of the different primary care providers; to bring together, if there is a hospital in that area—there will be referring hospitals, at least—to bring together the other kinds of resources—as we've learned through the health links initiative, to bring together the organizations that are actually outside the health system but are absolutely fundamentally critical to good health: policing, for example, which is quite an important piece in mental health care and so on.

More than anything, that's the transformational part: the ability to bring those people together; for a LHIN to be able to use its funding ability to shift funds around so that the care can be looked at from the point of view of the people living within that community and how we bring all these parts together.

The Chair (Mr. Monte McNaughton): Thank you very much. The two minutes are up. Thank you for your presentation today.

Ms. Angie Heydon: Thank you.

The Chair (Mr. Monte McNaughton): Next up is Spinal Cord Injury Ontario. They're not here yet.

PATIENT OMBUDSMAN

The Chair (Mr. Monte McNaughton): We'll now call for the Patient Ombudsman, please. Good morning.

Ms. Christine Elliott: Good morning.

The Chair (Mr. Monte McNaughton): You have nine minutes for your presentation, followed by two minutes of questions, starting with the third party.

Ms. Christine Elliott: Thank you. I will be following the information contained in the document in large print, and the additional document has additional information for your consideration.

I'd like to thank you for the opportunity to present my views on the impact of Bill 41, the Patients First Act, on the role of the Patient Ombudsman's office.

I want to congratulate everyone who had a role in establishing this office in the first place. It's both an honour and a privilege to have been chosen as Ontario's first Patient Ombudsman, and I'm committed to collaborating with patients, caregivers and health sector organizations to find solutions and drive positive change in health care.

Earlier this year, my office undertook broad-based, in-person and online consultations where we heard from hundreds of patients and caregivers from across the province about their expectations, fears and perceived limitations of the Patient Ombudsman's office. It is within this context that I offer two recommendations for your review.

(1) Jurisdiction: The Patient Ombudsman should be the specialized, single point of access for all patient health care complaints relating to the local health integration networks, including the health service providers for which the LHINs are responsible. In order to best serve the needs of the patient community, once the LHINs subsume the community care access corporations, patients should be able to come to one office to have their health care complaints resolved. To truly put patients first, Bill 41 must reduce and eliminate, where possible, confusion and fragmentation for the patient community.

(2) Governance: To attain the highest degree of credibility with patients and health sector organizations, the Patient Ombudsman must attract both the appearance of independence and actual independence. To this end, the Patient Ombudsman should be an independent officer of the Legislature.

I'll discuss the jurisdiction issue first.

The Ontario Ombudsman is responsible for the investigation of complaints against Ontario government ministries and agencies, including the Ministry of Health and Long-Term Care, as well as the LHINs.

In 2014, schedule 5 of Bill 8 amended the Excellent Care for All Act to establish the role of the Patient Ombudsman, who has the authority to receive, attempt to resolve and investigate complaints by patients and caregivers about public hospitals, long-term-care homes and community care access corporations.

Bill 41 then proposes to amend the Ombudsman Act to carve out the limited jurisdiction of my office and leave the remainder of LHIN complaints in the Ontario Ombudsman's jurisdiction.

There is a high degree of confusion in the mind of the public about the respective jurisdiction of the Patient Ombudsman's office versus the Ontario Ombudsman's office. It is anticipated that the passage of Bill 41 will result in more patient confusion and frustration with the merger of the CCACs into the LHINs.

I would propose a different, more streamlined approach for your consideration: Create a single, specialized place to receive patient complaints and examine fairness in the health care system by amending Bill 41 to allow my office to deal with complaints concerning all aspects of the LHIN operations going forward, not just home and community care complaints, as well as all of the health service providers for whom the LHINs will be responsible.

0920

In support of this recommendation, I offer the following arguments:

(1) It is consistent with the government's goals and objectives. On October 29, 2014, the Honourable Deb Matthews, then-Minister of Health and Long-Term Care, stated, in second reading debate on Bill 8, that:

"Our government believes that a sector-specific approach is the right approach when it comes to oversight

in health care. The Patient Ombudsman would focus specifically on health care issues and build on expertise, structures and processes already in place in organizations across the health care system, many of which are specialized and knowledge-intensive. The Patient Ombudsman's powers and responsibilities are closely based on those of the provincial Ombudsman, but would be tailored to the health care system context. These proposed changes would build on our efforts to improve the patient experience and quality of health care in Ontario, and would provide additional support to Ontario's patients."

It is clear that the intention of the government was to allow the Patient Ombudsman's office to focus on health care issues, and the fact that the Ontario Ombudsman has oversight over the LHINs is a historical anomaly that I request be discontinued.

(2) It makes sense from the perspective of patients and caregivers. If the intention of Bill 41 is to create a seamless, integrated home and community care system, it doesn't make sense to create a complaint resolution system that is both fragmented and hard to navigate, and is limited to only one segment of the LHIN system.

(3) The LHINs would only be subject to the oversight of one Ombudsman instead of two, which would streamline processes for them as they work to carry out their significantly expanded mandate.

I will now deal with the governance recommendation.

The Patient Ombudsman is an employee of the Ontario Health Quality Council. The Excellent Care for All Act gives the council the mandate "to support the Patient Ombudsman in carrying out his or her function." I have repeatedly heard from patients and caregivers that they are skeptical that my office has the requisite independence of an Ombudsman.

The patient community wants a fair, strong and independent Ombudsman who has final decisions over hiring and firing her own staff to whom she may delegate the statutory powers of resolving complaints and conducting investigations, and does not have to answer to a board that has assumed oversight over her operations.

The Patient Ombudsman should be an independent officer of the Legislature for the following reasons:

(1) It eliminates the potential for conflict of interest. There is significant concern about the fact that there are members of Health Quality Ontario's staff, the OHQC board and various Health Quality Ontario committees who are affiliated with, or employed by, health sector organizations over which the Patient Ombudsman has jurisdiction.

(2) It avoids the limitations of the employer/employee relationship. The employer/employee relationship creates an inherent power imbalance which could lead to interference with, or obstruction of, the investigation of patient complaints.

(3) It removes the Patient Ombudsman from the application of the Freedom of Information and Protection of Privacy Act in order to protect the obligation to keep investigations private.

(4) It eliminates the potential for interference from Ontario's Ombudsman. Since the Ontario Health Quality Council is under the jurisdiction of the Ontario Ombudsman, my office also falls under the Ontario Ombudsman's jurisdiction. It is conceivable that the Ontario Ombudsman could assert jurisdiction over the substantive nature of the investigations conducted by my office, in which case my office would be rendered virtually irrelevant.

In conclusion, there are very significant pre-existing perceived constraints in the minds of patients and caregivers about the efficacy of my office that will be exacerbated by this governance structure and jurisdictional framework.

People have overwhelmingly indicated they do not want their negative health care experience to happen to anyone else, and they want the Patient Ombudsman to be the "conduit" to bring the patients' voice to the policy- and decision-makers to drive positive change.

I would respectfully request that in order for my office to achieve its statutory and moral mandate to Ontarians, the Patient Ombudsman's office should be the specialized single point of access for patient complaints relating to the LHINs, including the health service providers for which the LHINs are responsible, and the Patient Ombudsman should be an independent officer of the Legislature to enshrine both the appearance of independence and actual independence.

I would be grateful for your consideration and acceptance of these two recommendations. The proposed jurisdictional changes could be achieved by amendments to the Excellent Care for All Act and the Ombudsman Act. Draft amendments have been appended for your review.

Thank you for your consideration of the foregoing matters. I look forward to your questions.

The Chair (Mr. Monte McNaughton): Great. Thank you very much. We'll move to Ms. Armstrong.

Ms. Teresa J. Armstrong: It's good to see you again, Christine.

Ms. Christine Elliott: Thank you. It's nice to see you too, Teresa.

Ms. Teresa J. Armstrong: Thank you for your presentation.

Am I to understand that this is the first time we've heard that this is the amendment proposal—that you become an independent officer of the Legislature?

Ms. Christine Elliott: Yes. I know this was discussed during the debates on Bill 8, and it was decided at that time that the Patient Ombudsman should be an employee of Health Quality Ontario. But, yes, since I have taken office, it has become clear to me, from the consultations I've had with hundreds of patients and caregivers around the province, that they really want to see the ombudsman's office be strong and independent. The present structure really just doesn't allow it, for the reasons I've indicated.

Ms. Teresa J. Armstrong: Okay. I have a constituent back in my riding who sent me some questions that are very important to him with regard to the Patients First Act. I'm going to ask the first question; I know I'll only be able to get to the one.

He'd like to know: Will the Patients First Act truly provide straightforward and easy-to-access, self-directed care funding options in which clients and their caregivers will be able to hire their own provider or purchase services from a provider of their choice? Will it include increased access to self-directed care funding options, such as individualized funding, indirect funding and individual service funds?

Ms. Christine Elliott: I think that's outside of the scope of my presentation today and probably would be best answered by the minister's staff.

Ms. Teresa J. Armstrong: We did refer them to the minister, but I wasn't sure if you had that insight with regard to the direct funding.

You've made the recommendation for the Patient Ombudsman office to be independent and to have full authority over the complaints about the LHINs.

Ms. Christine Elliott: Yes.

Ms. Teresa J. Armstrong: If that doesn't happen, how do you see Bill 41 obstructing that?

The Chair (Mr. Monte McNaughton): Ms. Armstrong, I'm sorry, but the two minutes are up.

We'll move to Ms. Kiwala, from the government.

Ms. Sophie Kiwala: Thank you very much for being here today. It is a pleasure to see you here in the House again. Welcome back. Welcome home.

Ms. Christine Elliott: Thank you.

Ms. Sophie Kiwala: In your capacity as the Patient Ombudsman, you are obviously a portal for patient complaints. One of the things that I'm hoping you can talk about today is with respect to the main goals of the Patients First Act: improving patient engagement and making patients first. Can you please talk about how the transformational changes within the bill will help strengthen patient voices at the local level and at a provincial level?

Ms. Christine Elliott: I think that just having the Office of the Patient Ombudsman open for people has been—people have received it extremely well. We've received over 600 complaints in our office since we opened on July 4. That indicates to me that there is overwhelming interest in the office.

Wherever I've travelled, people have said, "We are so hopeful that you're going to be able to make the change that we hope will come about as a result of Bill 41." But on the same side, they're still skeptical about how that can be done, given the constraints of my office and the fact that I'm not an independent officer of the Legislature.

My biggest concern out of all of this is the fact that because I am an employee of Health Quality Ontario—some of the people who are on that board and who are maybe employees of Health Quality Ontario are also affiliated with the organizations over which my office has jurisdiction. To me, that sets up an inherent conflict of interest and makes it really difficult for us to be able to do our jobs. If I am an employee of Health Quality Ontario and, say, for example, I want to do an investigation in Thunder Bay that's going to take six weeks and is going to cost a lot of money, it might be a problem.

The Chair (Mr. Monte McNaughton): I'm sorry, Ms. Elliott, but we have to move to Mr. Yurek now.

Mr. Jeff Yurek: How are you?

Ms. Christine Elliott: Fine. It's nice to see you, Jeff.

Mr. Jeff Yurek: It's good to see you. Jenn saw you on Focus Ontario yesterday. She told me I have to watch it, so I'm going to try to do that.

Thanks very much for your presentation. It was good.

We're really supportive of making the Patient Ombudsman independent. I don't think you could have your first point, the one point of access, until you have independence. I think you're right: It will overrun with the Ontario Ombudsman.

Have you received many calls from patients about health service providers that you can't really oversee? Are you getting complaints at your office about this?

Ms. Christine Elliott: Yes, there are a lot of them that we get where it might be—say, for example, a community mental health agency that would be under the jurisdiction of the LHINs, so that's not something that we can have any part of. That would have to go to the Ontario Ombudsman.

To be honest, most people really don't know the difference between a LHIN and a CCAC. They just know that they need more health care for their parent, for example. It's very confusing for people; they get really angry sometimes with our office because they'll say, "You're the health care ombudsman; why can't you deal with it?"

When you look at the history of the set-up of the office, it doesn't really make sense, and I think the Ontario Ombudsman really only has jurisdiction because they always have. It doesn't really make sense now, I would submit.

Mr. Jeff Yurek: So it would make sense to have the focus of health care under one ombudsman instead of multi—

Ms. Christine Elliott: Yes, at least as far as the LHINs are concerned.

Mr. Jeff Yurek: Okay. So the need is there; you're showing it. And hopefully the government will follow through in the amendments—but we'll be supportive of those going forward.

Ms. Christine Elliott: Thank you. I appreciate it.

The Chair (Mr. Monte McNaughton): Excellent. Thank you very much. Thanks for your presentation.

Ms. Christine Elliott: Thank you; my pleasure.

The Chair (Mr. Monte McNaughton): We've had two cancellations this morning, so the committee is aware. The 9:15 has cancelled and the 9:45 has cancelled.

I'd like to call, if they're here now, DoctorsOntario. Is anyone from DoctorsOntario here?

Okay. We're going to take a recess until 10 a.m.

The committee recessed from 0931 to 0959.

DOCTORSONTARIO

The Chair (Mr. Monte McNaughton): Welcome back to the Standing Committee on the Legislative

Assembly for public hearings on Bill 41. Our next presenter is DoctorsOntario. You'll have nine minutes for your presentation. If you could just state your name for Hansard and begin your presentation.

Dr. Douglas Mark: Thank you. Good morning. My name is Dr. Douglas Mark. I am the interim president of DoctorsOntario. We're a member-driven, grassroots organization dedicated to protecting the rights, freedoms and independence of Ontario physicians and our patients by promoting sustainable health care policies and practices that safeguard accessibility and the highest standards of medical care since 1996.

They say that every great journey begins with but a single step. With this in mind, I'm going to do something a little different this morning. Instead of focusing on what's wrong with Bill 41, the Patients First Act, and making suggestions as to how this particular piece of legislation might be improved, I'm going to go down a different road. I've entitled my remarks "Bill 41, the Patients First Act: The Right Solution to the Wrong Problem." Hopefully, you'll find my remarks as interesting as the journey our fellow Ontarians are about to embark on.

Of course, before we can figure out where we are going, it's important to know where we've been. As most of you know, the health care highway is littered with earnest, heartfelt attempts by previous legislators to fix what's wrong with our health care system: Bill 26, the Savings and Restructuring Act, 1996; Bill 8, the Commitment to the Future of Medicare Act, 2004; Bill 46, the Excellent Care for All Act, 2010; and, most recently, Bill 119, the Health Information Protection Act, 2016. Clearly, Ontario's legislators have been very busy during the past two decades.

But it is our future I'm concerned about, which is why I cancelled my appointments this morning: so I could come down to Queen's Park to speak with you about the Patients First Act. I'll be honest with you: I wish I didn't have to do this. I'd rather be spending the time with my patients, fixing their problems. Unfortunately, if you pass this deeply flawed piece of legislation, it's going to become more and more difficult for me and the rest of the province's 28,000 doctors to provide the kind of care our parents need and deserve. This is why DoctorsOntario is calling upon Premier Wynne and Dr. Hoskins to withdraw Bill 41 before it's too late and go back to the drawing board.

By now, you're probably wondering why I think the Patients First Act is the right solution for the wrong problem. You're also probably wondering what specifically is the problem we should be concerning ourselves with. Those are both good questions. Let me start with the first one. Bill 41 would be an excellent place to start if you felt it was impossible to bring all the health care stakeholders together in a collegial way in order to figure out what's wrong with our system and how we might fix it. In other words, if it was clear that things had deteriorated to such a point where we were spinning our wheels and it was apparent that real progress couldn't be made now or in the future, then by all means, it would be pretty easy to justify introducing a piece of legislation like the Patients First Act. Under those circumstances, it would make sense to anoint Dr. Hoskins emperor and give him full ministerial powers to rule as he sees fit. The problem with this approach, of course, is that when it comes to our health care system, the emperor has no clothes. Despite all the barbs and innuendoes, much of it coming from the health minister himself, there still remains an awful lot of goodwill out there. Doctors especially, despite having been without a contract for the past two and a half years, still want to work with the government in order to help restructure our health care system. But here's the problem: It's hard to reach out and shake hands and be partners with someone when you have to constantly count your fingers just to make sure none are missing.

So if Bill 41 is the right solution to the wrong problem, what is the right problem? What problem specifically should we be trying to find a solution to? It's simple: Our health care system, as it is currently structured, is unsustainable. Former Premier Dalton McGuinty had it right when he said not so long ago, "There will come a time when the Ministry of Health is the only ministry we can afford to have—and we still won't be able to afford the Ministry of Health." To put it another way, our system is like a car that needs a new transmission, a brake job and a new set of tires that actually have tread on them. Unfortunately, with the Patients First Act, all you are doing is slapping on some shiny new hubcaps and making sure there's enough water in the radiator so that you can get a few more miles out of the old heap.

Well, here's a news flash for you: Your band-aid solutions aren't going to work. "Good enough" simply isn't good enough anymore. If you're serious about fixing what's really wrong with our health care system, then you have to start by being honest with the people of Ontario. We can't afford to carry on like we have over the past two decades, with our collective heads buried in the sand.

The health care tsunami is coming, folks, the likes of which we've never seen: an epidemic of obesity, diabetes and dementia. And I'm not just talking about the costs of treating these diseases and the burden they will place upon our loved ones. We have to get a lot more serious about prevention and educating the people about what they're doing to their bodies and what their bodies are soon likely to do to them.

We're nowhere near prepared for what's coming, but we can do something about it, if only we have the courage to stand up, speak out and tell the truth—which is where you, Ontario legislators, come in. Instead of trying to ram the Patients First Act through the Legislature and have it become law by January 1, 2017, why not slow down and take the time to get it right?

As a doctor, I'm in the problem-solving business, so here's my solution: You need to shake your heads and get with it. Ontario's health care system doesn't need more highly paid bureaucrats, as will be the case should you pass Bill 41, or more power for the health minister,

who has already shown he has little interest in listening to doctors. No; what Ontario needs is a hybrid health care system, one that blends the best of both public and private systems, which, believe it or not, is working quite well in just about every jurisdiction around the world.

Before any of you go wrapping yourself in the Canadian flag and invoking the name of Tommy Douglas, you should remember this: The so-called father of medicare never intended our health care system to turn into the gear-grinding, tail-chasing, treasury-emptying, bureaucratic-driven mess it has become.

While you're at it, you might also want to keep in mind the following: Nowhere in the Canada Health Act will you find quality listed as one of the five pillars of Canadian medicare, which means that while quality may be job one at Ford, when it comes to our health care system, quality is clearly job none.

I see that my time is just about up. You've been very patient with me, and I thank you for that. Just before you part, however, I'd like to say a few words about leadership and end by making a special request of all of you who have gone to the trouble of listening to me this morning. Someone once said that a leader is one who knows the way, goes the way and shows the way. I like that. Someone else once said that management is doing things right; leadership is doing the right things. I think that about nails it.

As I said more than once during my presentation today, Bill 41, the Patients First Act, is the right solution to the wrong problem. If you can convince the Premier and the Minister of Health to work with doctors instead of vilifying us and trying to make us out to be public enemy number one, then I believe that together we can make a difference and turn things around. But we need to act fast.

So be brave, be courageous, but most of all be honest with the patients of Ontario. Let's start dealing with real threats to our health care system, not imaginary ones. Kill Bill 41. We can do better than this. We have to.

The Chair (Mr. Monte McNaughton): Thank you very much. We'll move to the government and Mr. Anderson.

Mr. Granville Anderson: Good morning. Thank you, Dr. Mark, for being here, and thank you and all the doctors for the wonderful service you provide for all Ontarians—

Mr. James J. Bradley: —which both the Premier and the minister have said on many occasions, I remind the presenter.

The Chair (Mr. Monte McNaughton): One at a time, please.

Mr. Anderson.

Mr. Granville Anderson: Right; we're not the enemy. You alluded to the fact of the booming health care system. Most of the budget in the province, as you know, goes towards health care. You said that that will increase. So we have to take steps to minimize that. We have to make sure patients are our priority.

I had the opportunity to visit a facility in my riding. It was $8 million spent to build it. I had a tour and there were about 30 doctors in there, and you know what? They weren't radical; they just wanted what's best for their patients, and we had a very frank discussion about the health care system. I talked about privatization. I looked at what's happening south of the border. What you've alluded to is private-public, and we see the disaster that has been.

It's not perfect in Ontario. There's work to be done; I will be the first to admit that. But it's not the worst system. It's a system that we can improve on without having the private system, and I don't think the public wants a private health care system in this province. If you look throughout Europe, the health care system works pretty well and patients are pretty well taken care of.

That's the goal. That's what we're striving for in Ontario. We can't do it without your help and government, doctors, patients, everybody working together to make that happen.

Having said that—

The Chair (Mr. Monte McNaughton): Sorry, Mr. Anderson, the two minutes is up. We'll move to the official opposition and Mr. Yurek.

Mr. Jeff Yurek: Thanks for coming in, Doctor. It's good to see you.

You've said a lot in so little time, making mention with regard to the lack of consultation with doctors. We've heard from the OMA, and they said they weren't consulted. We've heard from some patient groups. They weren't consulted. Was DoctorsOntario contacted and had some consultation?

Dr. Douglas Mark: No.

Mr. Jeff Yurek: You made mention of the Minister of Health vilifying doctors. Just last week, he said that the OMA came as close to lying as humanly possible after their testimony. I know that DoctorsOntario and OMA aren't always on the same page, but it seems to me on Bill 41 that all doctors seem to be on the same page. Can you comment?

Dr. Douglas Mark: Oh, absolutely. You have to get rid of this bill. It's nothing but an invasion of our practices. Government officials are going to raid our practices and look at patient records. It says it right here—I've highlighted all the parts in this bill. You can't push this bill through—absolutely not.

To reply to our Liberal government, the health care system in the United States is one of the worst in the world. You can look at the rankings. The Commonwealth Fund and the Bloomberg report recently—places like that rank the US system near the bottom. There are many, many countries well above ours. World Health said that we were 30th and the Americans 37th. Why would we emulate the American system? Virtually every country in the world does a better job and can save us money as well.

Mr. Jeff Yurek: Do I have time?

The Chair (Mr. Monte McNaughton): Twenty seconds.

Mr. Jeff Yurek: It's just that you mentioned the Commonwealth Fund. I noticed that Canada, with wait

times for surgery, is just above the States, but we're still like 12th, I believe, out of all the countries?

Dr. Douglas Mark: Yes. We're ranked near the bottom in this one here. A cataract surgery patient last week told me that she has to wait nine months. She can barely see. I don't even think it's safe for her to drive. Nine months in Toronto.

Surgery for hips and knees: If you have a bad hip or knee, it takes two to three years to get that done. And this is not—

The Chair (Mr. Monte McNaughton): We're out of time.

Sorry. We'll move to the third party. Madame Gélinas.

M^me^ France Gélinas: You pointed directly to the part in the bill that bothers you the most, answering the question from my colleague, and that is the fact that a supervisor could be appointed by the LHINs to go into a family health team and request patient records. Is this the way that you interpret the bill as well?

Dr. Douglas Mark: It's not interpretation. It's in plain English right here. I've highlighted the parts. It says, at 12(1) and another section further down, "records of personal health information." It's right there.

M^me^ France Gélinas: Have you ever seen anything where people were able to access patients' records except through a court? Does that exist anywhere else that you know of?

Dr. Douglas Mark: When we are audited or we have reviews by our college to ensure we're providing proper professional care, that's when the records are looked at. That's correct, and that should be done. We have that in place already.

This is a bureaucratic nightmare. They're going to be looking at what we pay our staff, the hours they work, the hours we take holidays and whatnot. We are a private practice, so we pay all our bills ourselves. This is an invasion of our practices.

That clinic you mentioned that's nicely built: They probably put a lot of their own money into that too. Will they want bureaucratic people coming in to tell them they're doing things right or wrong and to work more hours? Seventy-five per cent of Ontario's doctors are burned out—75%. We need 40% more doctors and 40% more hospital beds in this province. That's what I'm here to talk to you about. That's why this bill has to be cancelled as it's written.

M^me^ France Gélinas: Thank you.

The Chair (Mr. Monte McNaughton): Great. Thank you for your presentation.

We're going to be reconvening at 6 o'clock tonight. I'd like to let all committee members know that there's going to be dinner provided at 5:30 this morning in the dining room in the—

Mr. Granville Anderson: This morning?

The Chair (Mr. Monte McNaughton): Sorry—this afternoon, in the anteroom just to the back of the dining room. We will continue at 6 o'clock with public hearings tonight.

The committee recessed from 1014 to 1800.

The Chair (Mr. Monte McNaughton): Good evening, everyone. We're going to resume public hearings on Bill 41 at the Standing Committee on the Legislative Assembly.

ONTARIO COMMUNITY SUPPORT ASSOCIATION

The Chair (Mr. Monte McNaughton): I'd like to call, for the first presentation, Ontario Community Support Association. Good evening. If you would each first state your name for Hansard, and then you'll have nine minutes for your presentation. Questions this evening will start with the official opposition.

Ms. Deborah Simon: Sure. Deborah Simon. I'm the CEO of the Ontario Community Support Association.

Mr. Patrick Boily: Patrick Boily, manager, policy and stakeholder engagement with the Ontario Community Support Association.

Ms. Deborah Simon: I want to thank you for the opportunity to appear before the committee and to provide the perspective of the not-for-profit home and community sector on Bill 41.

I've already introduced myself. Our association represents over 270 not-for-profit organizations across the province that provide compassionate, high-quality home care and community support services to over one million Ontarians.

You are no doubt familiar with our organizations in your ridings that provide services to seniors and to people with disabilities, such as in-home nursing and personal support, Meals on Wheels, Alzheimer day programs, transportation, medical appointments and supportive housing, to name just a few.

Our sector offers over 25 health and wellness services that support over a million Ontarians. This includes the delivery of over three million meals, providing two million rides, and over 225,000 clients in the adult day programs.

A number of our agencies' outstanding work was recently recognized by the province. OCSA members were some of the team medal recipients of the Minister's Medal Honouring Excellence in Health Quality and Safety. A number of our individual organizations from our membership were named to the honour roll. The number of OCSA members recognized highlights the exceptional quality of care our members deliver.

On the question of Bill 41, OCSA and its members have a favourable impression of the Patients First Act and welcome the main objectives of the bill and many of its key elements. The proposed changes in the bill would lead to greater collaboration between the sectors and greater focus on population health, which is an initiative that many of our organizations support.

However, the proposed legislation is not without significant areas of concern. If these areas of concern are not addressed, OCSA will be unable to continue our support of this legislation.

We have categorized our concerns under six broad recommendations, which have been summarized in the handout provided to you.

Our top concern is the ability for the LHINs to contract out the delivery of community support services to for-profit providers under the new legislation. Although we believe that the creation of this new loophole was unintentional, our support is contingent on the resolution of this issue. As it is currently written, and as we understand it, the legislation dramatically increases the likelihood that LHIN-funded community support services, such as Meals on Wheels, senior services and adult day programs, could be provided to for-profit companies.

When the LHINs are made approved agencies under the Home Care and Community Services Act, they will have the authority to contract out community support services. To our understanding, there is no language which specifies that these services must remain not-for-profit.

To protect the quality of patient care and the sustainability of the health system, the legislation must protect and strengthen the not-for-profit delivery of community support services. Delivery of publicly funded community support services by for-profit agencies would put the quality of care received by clients at risk. In addition, it could lead to a loss of much-needed funding in several ways: A portion of public funding would go to profit rather than to the provision of service; significant charitable donations currently made to the home and community sector would be lost; and, lastly but not the least of which, volunteer service, the bedrock of not-for-profit community support services, would decrease, as individuals will not volunteer in a for-profit environment. Currently, volunteers contribute over three million hours of service each year, so that's a potential loss of up to $81 million if it were replaced by paid staff.

OCSA members have deep roots in their communities, and we do this work for purpose, not profit. Surpluses are reinvested in community, and the quality of care is never sacrificed by shortcuts designed to boost profit margins.

Included in the handout you have been given is proposed language that would close this loophole and maintain the current not-for-profit nature of community support and service delivery.

As I have mentioned previously, we understand that it was an unintentional consequence of the changes, and that there is some work that is being looked at right now on that.

OCSA's second recommendation relates to care coordination. When an individual is being served by the CSS agency, it makes sense that care coordination be provided by that same CSS agency. The service provider knows and manages the care of the client. Overall, wherever care coordination is situated, it is critical that the service be fully integrated into the full continuum of health services that may be required by the client. This issue is of great concern to our members, many of whom are successfully providing care coordination services in their communities. But this is not directly addressed by the legislation.

Moving on to our third issue, as has been highlighted by other presenters, we have grave concerns around the LHINs' ability to appoint supervisors of community-based providers. Many not-for-profit organizations that provide home and community support services receive funding from multiple sources, not just the Ministry of Health and Long-Term Care. This could include other ministries, the federal government, charitable foundations, and individual donors. Should the LHIN appoint a supervisor to replace the board of directors, as indicated in the legislation, it could result in the LHIN controlling all organizational assets, programs and property, including those that they do not have direct funding authority over. This could put other source funding at risk.

OCSA has also developed two recommendations to address this concern. First, we recommend that the conditions under which a LHIN can appoint a supervisor be further defined and include approval from the Ministry of Health and Long-Term Care. In addition, a policy governing the powers and the appointment of the supervisor of an agency with multiple streams of funding must also be created.

Lastly, I'd like to raise two critical issues that go beyond the legislative framework but are crucial to our sector's ability to function and innovate effectively within a transformed health system.

The vast majority of home and community support has gone several years without an increase to base funding, restricting the capacity of agencies to innovate or create efficiencies by investing in new technology or improving training.

While the government is keen to shift the provision of care out of more expensive institutions and into the community, sector providers have not received funding we need to build our capacity to meet this challenge and the shift.

In recent years, only three LHINs have recognized the impact that this has on our CSS members and have allocated base increases of just 1%.

OCSA wishes to see a strong signal that cost savings arising from the reduction of administrative bureaucracies under the Patients First Act—for example, as the CCACs fold into the LHINs—that these funds be reinvested into front lines and the operations of home and community sector providers, to allow us to make the needed changes to deliver essential client care.

In addition, there are a few references in the legislation to key populations with unique needs, such as those with physical and cognitive disabilities and medically complex children. Specialized services such as supportive housing and independent living services are an important and distinct form of care within the community and must be treated as such in the planning and organization of health delivery.

OCSA is pleased to continue to offer our unique insights, experience and expertise to the implementation of these reforms.

At this point, I would welcome any questions to explain further the rationale behind our recommenda-

tions, and invite members to use our MPP handouts as a springboard for more discussion.

Thank you.

The Chair (Mr. Monte McNaughton): Great. Thank you very much. We'll move to Mr. Yurek of the official opposition.

Mr. Jeff Yurek: Good evening.

Ms. Deborah Simon: Good evening.

Mr. Jeff Yurek: Thanks for coming in tonight. A question with regard to the cost savings arising from the reductions: Do you have any idea—has the government given you any idea—of how much money is actually going to be saved?

Ms. Deborah Simon: What we're understanding is that there would be a net savings of between 5% and 8% in administrative savings. That's what we're hearing from those folks we're talking to.

Mr. Jeff Yurek: Okay. I haven't seen any of those numbers out in front of this. There would be major transformation going on in the health care sector, and promises of savings that are going to be realized. We'd like to possibly have seen some sort of number—

Ms. Deborah Simon: If there are savings, certainly it's our position that we would like to see those savings folded into the providers who deliver the services. As I stated in my speech, these providers have not had increases for a number of years.

Mr. Jeff Yurek: Sure. The other point, about the appointment of a supervisor: We've had other groups in here with the same concerns about not receiving 100% of the funding. Should it be fully 100% for them to take over an agency or direct it?

Ms. Deborah Simon: No, I think the point is that there needs to be some recognition that not all services that are delivered by the LHINs are 100% funded by the LHINs. Most of our organizations delivering these services have multiple service funders. If, for instance, one of the providers was appointed a supervisor because their performance indicators may not be what the LHIN was looking for, but they may have been delivering and meeting all the targets for other funders—we don't want to have that jeopardized as a result of the appointment of a supervisor.

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Mr. Jeff Yurek: Great. Thanks.

The Chair (Mr. Monte McNaughton): Madame Gélinas.

M^me^ France Gélinas: Thank you so much for coming. As always, it's a pleasure to see you. I would say that the NDP shares your concern about opening up the door to for-profits. With the home care act, the for-profits were supposed to be for services that the not-for-profits were not providing, maybe in palliative care etc. We have seen that once this door was opened, now most of the home care services are provided by for-profit agencies. We're about to do the same thing for community supports.

From your standpoint, how important is it that the bill be changed to focus on not-for-profits?

Ms. Deborah Simon: We feel this is really critical. This is certainly a significant point for our members, as we've polled our members and they indicated their concerns around this. But I think it's really important that you understand that our rationale for not wanting for-profit providers is simply not to support the status quo. We believe that not-for-profit delivery of community-based services delivers a big need, including significant funding issues for government if those services disappear.

It is an important issue. The delivery of services by volunteers in communities—this is absolutely essential going forward. So it is an important point to our organization.

M^me^ France Gélinas: Have you quantified the wage gap that happened? Because most of your members haven't seen a pay increase in eight years. Have you been able to quantify how many dollars we are talking about to bring you close to a pay scale that makes sense?

Ms. Deborah Simon: I don't have that number, but I'd be happy to try to quantify that.

But considering there have been cost-of-living increases year over year for about seven years, I think our sector is currently probably well behind others—

The Chair (Mr. Monte McNaughton): Excuse me, sorry. We're going to move to the government and Ms. Kiwala.

Ms. Sophie Kiwala: Thank you very much for being here today, Deborah. It's really a pleasure to have you and to hear your discussion and your deputation. You're clearly very committed to patient care, and I appreciate that.

As you know, one of the very strong pillars behind Bill 41 is the focus, that we would like to provide the right care in the right place at the right time. I have my own personal experience to draw from. My mother was diagnosed with cancer quite some number of years ago. We did have a number of for-profit agencies—I guess you're calling it that; I wasn't aware of it at the time—come in and look after her. I have to say that I had an outstanding experience. We did have volunteers that were part of that package of care, which was quite appreciated, I can tell you that.

I'm just wondering if you can suggest how your amendments, while offering patients and clients the option to pick an agency that they're comfortable with—how do you think that should be amended so that we can continue to provide patients with choice?

Ms. Deborah Simon: We have put forth some suggested wording that would essentially not change the abilities that currently exist to be able to have services provided by the most appropriate health care provider. Currently, under the Home Care and Community Services Act, the requirement by the LHINs right now is to provide those services through not-for-profit providers. I think in my presentation, I made the case about what the loss will mean to government if there is a slide in terms of the amount or number of providers—

The Chair (Mr. Monte McNaughton): Sorry, thank you very much. That's all the time for the question.

Ms. Deborah Simon: Thank you very much for listening. I appreciate it.

NURSE PRACTITIONERS' ASSOCIATION OF ONTARIO

The Chair (Mr. Monte McNaughton): We'll now move to the Nurse Practitioners' Association of Ontario.

Good evening. If you would both state your names for Hansard and begin. You have nine minutes for your presentation.

Ms. Theresa Agnew: I'm Theresa Agnew. I'm the CEO of the Nurse Practitioners' Association of Ontario.

Ms. Jane Fahey-Walsh: My name is Jane Fahey-Walsh, and I'm the director of policy at NPAO.

Ms. Theresa Agnew: Thank you very much. We're very pleased to be here to present on Patients First.

The Nurse Practitioners' Association of Ontario is the professional voice for more than 2,900 nurse practitioners across Ontario. Nurse practitioners are registered nurses with advanced university education and experience who provide a full range of health care services to all Ontarians. Nurse practitioners can prescribe all medications independently, with the exception of controlled drugs and substances. It is anticipated that by spring 2017, NPs will also be able to prescribe those drugs. Nurse practitioners can order and interpret all laboratory tests and some diagnostic imaging tests.

We look forward to the government removing the final outstanding Bill 179 barriers that are currently impacting patient care, and providing access to other tests, such as MRI and CT scans. NPs are also able to refer to specialists and to admit, treat and discharge hospital patients.

Nurse practitioners work across the health care system in a wide variety of settings, including hospitals, family health teams, community health centres, nurse practitioner-led clinics, long-term-care facilities, public health units and with home care and palliative care teams. In some settings, NPs provide primary care services to individuals and families, from newborns to the elderly, and often serve many of Ontario's most vulnerable and marginalized populations. In other settings, such as hospitals, NPs provide very specialized care, assessing and treating complex patients with multiple conditions. NPs place an emphasis on promoting health, preventing illness and injury, and reducing complications with a patient-centred focus. NPs aim to reduce unnecessary emergency room visits, reduce the length of stay for hospital patients, and ensure that people are well cared for as close to home as possible.

In general, NPAO supports Bill 41, the Patients First Act. We believe that it aligns with our vision for a strong, efficient health care system that provides the right care at the right time in the right place by the right provider. However, we do not think the bill goes far enough with putting patients first, and we have several recommendations in six areas to strengthen the bill and improve the performance of our health care system.

First, we are pleased that the bill has expanded the objects under the LHIN act, including the addition of health equity. As mentioned, NPs often serve marginalized people. However, NPAO recommends that an object pertaining to health promotion be added, along with definitions for key terms such as health, health equity and health promotion. It is important that the act demonstrates to all Ontarians, including health system planners, health care providers and patients, a commitment not just to the treatment of disease but also to the entire broad spectrum of health, including health promotion, wellness and well-being.

Second, NPAO believes that Bill 41 is an opportunity for the government to take bold and decisive action to implement a fully integrated health care system. We recommend that all funding for all health care flow through the LHINs, including physician funding. The bill does not propose this. We strongly believe that funding should wrap around the patient and family, not the provider. Following on the recommendations of the Drummond report, the province should continue to move from a fee-for-service payment model for physicians to paying for performance.

Third, NPAO recommends that the powers of LHINs over health service providers such as nurse practitioner-led clinics be clarified. This is particularly important given the authority of LHINs to appoint investigators and a supervisor.

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The bill states that health service providers may be subject to the appointment of a supervisor. Given that many HSPs receive funding from both government and non-government sources and are run by community boards, it is not clear how the LHIN would have the authority to supervise a community-run organization. Further, LHINs will also have the authority to investigate and report on quality of management, quality of care, treatment of persons, or any other matter in the public interest.

While NPAO fully supports governing in the public interest, the threshold for what constitutes such interest appears to be quite broad and open to interpretation. Therefore, NPAO recommends that the term "public interest" be clarified. Additionally, NPAO recommends that consultation and clarification are needed with respect to the powers of investigators under Bill 41 as they relate to the powers of health care regulators so that the bill does not interfere with or duplicate the powers of a regulatory college, such as the College of Nurses of Ontario. This is also important given that investigator powers include access to records that may include personal health information. In addition, the type of information that can be posted publicly and how it is posted is not spelled out in the bill and should be included in regulation.

Fourth, NPAO strongly supports that LHINs establish one or more patient and family advisory committees, as we believe it is essential to have the patient and family voice at the LHIN table. However, we are concerned that

the establishment of a health professionals advisory committee has been changed to "optional." NPAO recommends that this committee be made a requirement, and further that its composition be set out in the bill or in regulations to ensure that LHINs receive advice from all health professionals, including NPs. Without the requirement for the health professionals committee, the voice of a broad range of health care providers in health planning at the LHIN level may be muted. This is concerning as NPAO understands that broad provider representation at the LHIN level is not currently happening. For example, NPAO receives reports that nurse practitioner applications for the new LHIN primary care lead positions are being consistently rejected by the LHINs, and the composition of primary and community care committees does not appear to include a broad range of health care providers.

This approach seems inconsistent with the government's primary care guarantee that stipulates that all Ontarians have either a primary care physician or an NP. NPAO believes that full engagement and relationships with all key stakeholders are essential for the successful implementation of the act, rather than as an afterthought or mere tokenism. Further, NPAO supports the increase in LHIN board numbers from nine to 12 members. However, to ensure broader health care provider representation, NPAO recommends that the LHIN board composition stipulate this broader representation.

Fifth, NPAO supports better co-operation between the 36 current local public health units and the 14 LHINs. However, NPAO also believes that in order to enable full collaboration between LHINs and public health units, we recommend that the number and boundaries of the 36 public health units be reorganized to conform to the boundaries of the 14 LHINs. This amalgamation would create significant cost savings, consistency, and efficiencies in the system. In addition, to help ensure consistency and conformity across the province for public health services, funding should flow through the LHINs.

Finally, NPAO recommends that palliative care NPs currently employed at CCACs be transitioned so that the models of care in which they work make the best use of their skills and abilities in providing critically important care to their palliative care clients and at end-of-life.

In closing, we reiterate our support for the bill—

The Chair (Mr. Monte McNaughton): Sorry. I have to stop you there.

We're going to move to questions from the third party. Madame Gélinas.

M^me^ France Gélinas: Maybe I will start with your last one regarding NPs currently employed by CCACs. You would like them to transition to a community-based model—a hospice-based model, I take it. How do you see this happening and what time frame would you like to see?

Ms. Theresa Agnew: We understand there is a variety of factors that go into that transition. Ultimately, yes, we would like to see the nurse practitioners who are currently providing palliative care services, mental health services through the CCACs—we would like to see them transition into primary care settings in order to support the roster of patients who are currently provided in those settings.

Having said that, there are also a number of other innovative models that nurse practitioners are proposing. One includes forming a collective, so that nurse practitioners currently providing palliative care can do that in a LHIN or a sub-LHIN region.

We understand that this will take some time, and we are in favour of a review and of a transition.

M^me^ France Gélinas: How important is it for you and your organization that the patient and family advisory committee be mandated?

Ms. Theresa Agnew: It's very important.

M^me^ France Gélinas: Enough to influence your support of the bill?

Ms. Theresa Agnew: I would say that it's a key factor that has come forward from our members. We believe that a bill that's entitled "patients first" should truly involve patients and families at all levels.

M^me^ France Gélinas: You also have issues with the personal health information that may have to be shared. How important of an issue is it for you?

Ms. Theresa Agnew: Well, I'll share an anecdote: We recently received a call from a nurse practitioner-led clinic—

The Chair (Mr. Monte McNaughton): Sorry, that's time.

We'll move to the government. Mr. Fraser.

Mr. John Fraser: Thank you very much for being here, Ms. Agnew and Ms. Fahey-Walsh, again this week. It's been less than a week. I want to thank you for all of the work that you do.

I have a quick question for you, similar to Ms. Gélinas's question. I think the opportunity in Bill 41 is to create the conditions where people can collaborate and identify local priorities using local capacities. You were speaking about the transition of some palliative care and mental health nurse practitioners. Can you just elaborate about that a little bit more in terms of what you see?

Ms. Theresa Agnew: Of the approximately 3,000 nurse practitioners working across the health care system in Ontario, approximately 200 are currently working with CCACs. They provide a number of functions. Many of them are involved in palliative and end-of-life care. They are the team of people who help to organize care for people at the end of their life.

While we recognize that those positions would be moving from the CCACs to the LHINs, we're also interested in exploring new opportunities for nurse practitioners to provide palliative care services.

Mr. John Fraser: Okay, that's good. Do I have more time? How much?

The Chair (Mr. Monte McNaughton): Twenty seconds.

Mr. John Fraser: Twenty seconds? What can you say in 20 seconds?

Just in terms of opioids and prescribing: That will be coming this spring, and your comments with regard to Bill 179—those are things that we're actively working on. As you know, I have the scope file. I just want to put that back on the record.

Ms. Theresa Agnew: Thank you. We appreciate that.

The Chair (Mr. Monte McNaughton): With that, we'll move the official opposition. Mr. Yurek.

Mr. Jeff Yurek: It's good to see you again.

I'll get back to the third party's question regarding the access to health records and patient confidentiality. Continue on. We've had numerous groups who have concerns with that aspect.

Ms. Theresa Agnew: Yes. We recently received a call from a nurse practitioner-led clinic. They had received a letter of complaint from a patient, but that letter of complaint was copied to the LHIN and copied to the College of Nurses of Ontario.

The College of Nurses of Ontario, obviously, has an obligation to protect the public interest, and would naturally look into that complaint and determine if an investigation was required and if disciplinary action was required.

However, the NPLC received a call from the LHIN, stating that they would send in an investigator to that NPLC to investigate the client complaint and that they wanted to review the client's record in full. That is cause for concern.

Mr. Jeff Yurek: Any reason given why the LHIN wanted to investigate?

Ms. Theresa Agnew: Because they had been copied on the letter of complaint.

Mr. Jeff Yurek: Just because they had been copied.

Ms. Theresa Agnew: At this point in time, they might be under the impression that that's within their power, but it's obviously not yet. But even were it to be in their power, it causes us concern.

It also seems to be duplicative. It duplicates the role of the regulatory college.

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Mr. Jeff Yurek: Right, and we have the Patient Ombudsman as well if it was an oversight, so access to patient records probably isn't necessary from a LHIN investigator.

Ms. Theresa Agnew: Well, certainly you would want aggregate information and you'd want to know where the concerns are, where the gaps are from an organizational perspective, but with respect to the—

The Chair (Mr. Monte McNaughton): Thank you very much for your presentation tonight. That's all the time.

Ms. Theresa Agnew: Thank you very much.

ONTARIO PUBLIC HEALTH ASSOCIATION

The Chair (Mr. Monte McNaughton): We'll call the Ontario Public Health Association. Good evening. If you would just state your name for Hansard. You have nine minutes for your presentation.

Ms. Pegeen Walsh: Thank you for the opportunity to appear before your committee. My name is Pegeen Walsh, and I am the executive director of the Ontario Public Health Association.

Our non-profit, non-partisan association brings together those who are committed to improving people's health from the public and community health, academic, voluntary and private sectors. Many of our members, be they health nurses, inspectors, nutritionists, doctors, planners, health promoters, epidemiologists or environmental health managers, are working on the front lines to protect and improve public health in their communities.

Our association has been championing prevention, health promotion and protection for over 67 years. As such, we were very encouraged when the minister tabled this legislation and spoke about the need to "push further towards a wellness approach to the delivery of health services," and doing so in "an equitable way, in a way which reflects population health needs and impacts social determinants of health."

In keeping with this vision, we urge your committee to consider some amendments to the Patients First Act to ensure that these goals become an integral part of this transformation agenda.

Allow me to describe three areas where we're recommending changes, and the rationale. Our proposed changes would see a broader definition of health, a stronger emphasis on health promotion and the adoption of a Health in All Policies approach.

Thirty years ago today, Canada hosted an international gathering that led to the creation of the Ottawa Charter for Health Promotion, a charter outlining actions to achieve health for all. Since that time, evidence has been mounting: Investments in health promotion can result in significant reductions in hospital use and costs, and improved health. For example, Dr. Doug Manuel's recent study, The Ten-Year Impact of Improving Smoking, Alcohol, Diet and Physical Activity in Ontario, showed that comprehensive population-level strategies that work across the health continuum, such as Smoke-Free Ontario, can lead to significant savings—in this case, $4.9 billion over 10 years.

Patients First is that opportunity to embrace a broader vision of health and reorient health services as were envisioned over 30 years ago with the charter and subsequent reports. That's why we're recommending that section 5 of the act be amended by adding the following object: to develop and implement health promotion strategies in public health, primary care and community-based services.

Responsibility for health promotion in health services needs to be shared among individuals, community groups, health professionals, health services institutions and government, creating a health care system which contributes to the pursuit of health—and I apologize because I realize you have different phrasing than the one I just read.

We were pleased to see that this version of the legislation refers to the role of LHINs related to health equity.

We recommend that definitions of health, health promotion and health equity be included in the objects of this legislation, as well as the various mechanisms and tools used to implement it. Having these definitions included will better reflect recent evidence about the factors that influence health and well-being. We have included in our appendix the definitions that are used by the World Health Organization, the Ottawa charter and the Ministry of Health and Long-term Care.

Lastly, we know that health is so much more than hospitals, doctors, diet and exercise. Most of our health is influenced by factors that lie outside the health system, hence the need for a whole-of-government approach, commonly referred to as Health in All Policies.

We recommend that Patients First give the Minister of Health the power to require that other government policies and initiatives that could have a significant impact on health be assessed for their health and health equity implications. Will they improve health outcomes or have unintended negative health consequences? Will they contribute to reducing health care costs or increasing them? Various jurisdictions outside of Canada are embracing such an approach, and in Quebec, they have been leaders in adopting such legislation.

We believe our recommendations are patients-centred, will serve patients and can contribute to the sustainability of the health system. With our aging population, increasing costs of new medical technologies and growing rates of chronic diseases, a health system that does not have prevention and health promotion at its foundation tackling the underlying causes of poor health will not be sustainable.

Our proposed amendments will build on that foundation to create a culture of health and well-being, reduce inequities, improve planning and the delivery of care and outcomes, and better manage system costs.

We welcome the opportunity to work with legislators on achieving our shared goal of a more equitable and sustainable health system that improves health outcomes for all.

Thank you for giving me the opportunity to convey the ideas and perspectives of our members.

The Chair (Mr. Monte McNaughton): Thank you very much. The first questions will come from the government. Mr. Anderson.

Mr. Granville Anderson: Thank you, Ms. Walsh, for being here, and thank you for all the work you do in the field of health promotion.

I believe your suggestions in defining health equity and health promotion are great suggestions and similar to what we have heard from other stakeholders. I think that's the way—with spiralling health care costs, whatever we can do to reduce the impact of people getting ill, and keeping them well, is beneficial to all of us, and it's beneficial to the health care system and society as a whole. Do you want to expound on some areas in which you think we could improve on doing that?

Ms. Pegeen Walsh: Where to start? First of all, I think having those definitions will be great because, right now, you have "an act to amend acts" and there's nothing really that sets out a vision and goal, yet we hear the minister talk about those broad visions and goals. I think adding that will be significant. As well, giving the LHINs that power to be focused on health promotion and prevention will allow a more upstream approach—and looking at other members in the community and what other sectors need to get involved to tackle those underlying causes of poor health.

Mr. Granville Anderson: Okay.

The Chair (Mr. Monte McNaughton): You have time.

Mr. Granville Anderson: Can you speak as to how your members have seen health inequity across the system and the impact this legislation could have to reduce health inequities from the perspective of public health?

Ms. Pegeen Walsh: We know that key factors like education, income and one's social standing have a critical role on health. So by putting that focus on looking at the root causes of health, that gives an opportunity to improve health. Right now, we have a $50-billion budget, and 2% is focused on health promotion. We want to see that shift. Thirty years ago, there was a call for this kind of shift, and it's startling and disappointing that we haven't been able to see more of that—

The Chair (Mr. Monte McNaughton): Thank you very much. We have to move to the official opposition. Mr. Yurek.

Mr. Jeff Yurek: Thanks for coming in tonight. Could you just maybe briefly outline what you envision as public health's role with Bill 41? I've had off-line conversations with some members of public health, and they're concerned they'll just be a member of some committee down—part of the LHIN. Where do you see the big role of public health in this?

Ms. Pegeen Walsh: I think that public health has a lot of expertise to offer in terms of understanding the role of different sectors and how they contribute to health. They have an important role to contribute around population health planning, and they understand the role that inequities can play in society. I think the concern for public health is how they allocate resources so that they can play that planning role through the local health integration networks. There are already some terrific models where that is happening, so I think we want to build on those successful models and also look at what the resource implications are.

Mr. Jeff Yurek: Are you concerned, possibly, of having the necessary resources available throughout all of Ontario, considering the number of public health units that have been frozen with their funding indefinitely? Do you think there's a concern to make this transformation occur?

Ms. Pegeen Walsh: As mentioned by my colleagues at the Association of Local Public Health Agencies, that funding is always a concern. That's something to look at: How can public health support LHINs in that planning role and, at the same time, what would that mean in terms

of additional resources that would be needed to be able to play out that role to full effect?

Mr. Jeff Yurek: Okay. Thanks.

The Chair (Mr. Monte McNaughton): Madame Gélinas.

M^me^ France Gélinas: To continue on his line of thought, the care system has so little to do with keeping people well and so little to do with health promotion, disease prevention and public health in general. We've just added these mandatory relations with the LHINs at the same time as the government made it clear that your budget, as a sector, is frozen for as far as the eye can see. How do you reconcile the two? Public health has very little to do with the health care system, if you ask me, yet we're forcing you to do this, which means taking resources from public health to do something that has very little to do with public health.

Ms. Pegeen Walsh: In my remarks, I was talking about that there are ways to reorient health services to be looking at ways to embed health promotion. Right now, if you look across Ontario, there are models where public health is working on injury prevention with hospitals. They're working on child and maternity health. They're working on oral health. So there are opportunities to build on those models, and also to be clear what public health is well placed to do with the resources that they have. To go further, additional resources would be important.

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M^me^ France Gélinas: Would like you to see a one-way flow that—it doesn't take long for a hospital to suck the money out of everything around it, including public health. Any fears that way?

Ms. Pegeen Walsh: I think that's why it's important that in this version of legislation the budget for public health is outside of the LHIN. I don't think it's helpful for it to be included within the mandate and budget of local health integration networks. Our experience in other parts of the country is that that has diminished the role and resources of public health. I think we need to recognize the important contributions and role that local government has and those partnerships at the local level outside of the health system as well.

M^me^ France Gélinas: Okay. If it weren't in legislation, would you still collaborate with the LHINs?

Ms. Pegeen Walsh: As I mentioned, there's already collaboration happening that is having very positive outcomes.

The Chair (Mr. Monte McNaughton): Thank you very much. That's all the time we have for your presentation. Thanks for coming.

DYING WITH DIGNITY CANADA

The Chair (Mr. Monte McNaughton): I now call upon Dying With Dignity Canada. Good evening. If you would state your name for Hansard, you'll have nine minutes for your presentation, followed by two minutes of questioning, starting with the official opposition.

Ms. Shanaaz Gokool: Great. Thank you. Good evening. My name is Shanaaz Gokool and I'm the CEO of Dying With Dignity Canada. I thank the Standing Committee on the Legislative Assembly for including our organization at these proceedings.

Dying With Dignity Canada is the national organization committed to improving quality of dying. We work to uphold the Supreme Court of Canada's decision in Carter v. Canada and to ensure that medical assistance in dying, otherwise known as MAID—that the protocols are fair and compassionate and do not cause further harm to people whose health is already severely compromised.

My remarks today will be focused on the amendments in section 46(2), related to section 8 of the Public Hospitals Act, specifically on directives by the minister. On one hand, the amendment allows the health minister to issue an operational or policy directive to the board of a hospital where the minister considers it to be of public interest. But on the other hand, the minister is restricted with this amendment and cannot require the board of a hospital that is associated with a religious organization to provide a service that is contrary to the religion related to that organization.

To be clear, I'm not a doctor nor a lawyer, but I am a human rights activist, and it's the human rights framework that I would like to bring to the discussion today. The amendment in question speaks to the responsibilities and the rights of institutions as it relates to freedom of conscience and religion. Also, the amendment certainly has implications for discrimination in the provision of other health care treatments, but my comments today will be about the impacts and discrimination against the most vulnerable amongst us who are requesting aid in dying. Let's start with what we do know:

(1) Ontario hospitals, including faith-based hospitals, provide public health care with public funds.

(2) MAID is a legal medical treatment and has been since June 17, when the federal government passed Bill C-14.

(3) MAID has the stamp of approval of the Supreme Court of Canada, it's got the federal legislation, and it's an insured health service in all of the provinces and territories. It is part of public health care.

(4) Many religiously affiliated hospitals are opting out of providing MAID in Ontario and across the country. Additionally, many hospices and palliative care units also do not want to provide aid in dying on their premises.

(5) Ontarians, and indeed Canadians, are having assisted deaths in both institutional and in-home settings. Without institutional access, many Ontarians will be subject to prolonged suffering and possible physical and psychological harm if they are told that they must leave the hospital they are in because it refuses to provide medical assistance in dying.

(6) The provision of MAID does not require special equipment or a special medical designation of the health care practitioners involved. Hospitals cannot hide behind medical specialization. All that is needed is a room, a bed, appropriate life-ending medication and a willing doctor or nurse practitioner.

(7) We know from this freedom-of-information-act request that I've distributed to all of you that when we asked the Ontario Ministry of Health and Long-Term Care if they were tracking who is providing medical assistance in dying and which hospitals are opting out, we were told that not only is the minister not collecting this information, but that, "You may wish to contact each hospital directly."

Let's talk about conscience and medical assistance in dying. Dying With Dignity Canada believes that no health care provider should be forced to provide medical assistance in dying, either as a provider or as an assessor. However, we do believe that people who have health conditions that are so precarious where they may not be able to physically make a phone call require, at the very least, an effective referral to another doctor or nurse practitioner to help answer their questions and help them to navigate the health care system.

We cannot assume that a physically frail and dying person will have friends or family to do this for them. They need help from their existing health care providers, and they also need help from providers who have a duty not to abandon their patients.

When we're talking about institutions, Dying With Dignity Canada believes that all providers of public health care—hospices, hospitals and long-term-care homes—are tasked with the delivery of universal access to our medicare system. They receive public funds and are responsible agents of the province and territories in the delivery of health care programs.

There are a lot of things in our country that we may not be able to agree upon and that help to define who we are as a nation. I would say that access to health care is not only a definable feature of our country, but a feature that, while not perfect, is widely celebrated.

When we are talking about assisted dying and conscience, we simply do not believe that a public health care institution can claim only one conscience on behalf of all of the staff—including doctors, nurse practitioners, physician assistants and social workers—who work there, or on behalf of all the patients and residents within these facilities.

It's important to note that Quebec has had legislation since last December, and all hospitals and hospices are required—including the faith-based ones—to provide medical assistance in dying on their premises.

As I mentioned, not only are many faith-based public health care facilities opting out of MAID, but so are non-faith-based facilities. Hospices across the country are opting out of providing this. Hospice and palliative care units provide incredibly important work for suffering people, but people don't usually have a choice where they go for this kind of care, and this should not have to be a choice. Everyone who is eligible for assistance in dying and wants that option should still be able to have access to the best-quality palliative care. These are places where people go to die, and to allow them to opt out is cruel and unkind toward people who have intolerable and enduring suffering and who are so vulnerable and already grappling with the heavy decision of wanting assistance to end their lives.

For example, in Ottawa, Élisabeth Bruyère Hospital runs the largest palliative care facility in the area. There is no question about the quality of the palliative care in that facility. Choosing palliative care and medical assistance in dying are not mutually exclusive choices. Both should be available for people who are eligible and who choose it. You don't always know, when you start in palliative care, if you are going to want an assisted death or not, but you do have a right to an assisted death if you are eligible for it.

The Catholic Health Association of Ontario has issued a directive that all of their affiliated facilities will not only forbid medical assistance in dying on their premises, but they also will not provide information or even an effective referral for patients who request. Certainly, Bruyère says it will address MAID requests on a case-by-case basis, but that may fundamentally amount to no clear direction for staff or patients. Or, if this legislation passes as is, it may embolden hospitals like Bruyère to simply forbid staff from answering questions about MAID, full stop.

In Ontario, communities like Pembroke, Elliot Lake, Mattawa and others have only faith-based hospitals. Where are their residents supposed to go, should they make a request for aid in dying?

We know of the story, out of Vancouver, of Mr. Ian Shearer, who was at St. Joseph hospital and had to be transferred to Vancouver General in order to receive an assisted death. His daughter, Jan, said that her father, who had spinal stenosis, was in so much pain "just to touch him, he would scream." When he was transferred from the hospital bed to the stretcher, he yelled out in agony. She said that, during the 20-minute drive from St. Joe's to Vancouver General, he screamed the entire way.

So we know that there may be physical harm to be transferred out and psychological trauma for the person and the family who may feel abandoned by the hospital when they are essentially told, "Well, you were good enough to get care here, until you asked for an assisted death, and now we're going to have to kick you out. Yes, we know that your health is precarious; yes, we know you are vulnerable and you are dying, but our single hospital conscience is more important than your legal right, your charter right and your human right to an assisted death." I ask you all today, how is that even conscionable in 2016?

We know that there may be psychological harm done to the staff at these public health care facilities who will be denied their ability not to abandon their patient as they go through the final stages of their lives.

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Here is what I know as a human rights activist: Everyone has the right to conscience and freedom of expression. These are fundamental rights that are guaranteed in the Universal Declaration of Human Rights and in the Canadian Charter of Rights and Freedoms—

The Chair (Mr. Monte McNaughton): Thank you very much. We're going to move to the official opposition, and Mr. Yurek.

Mr. Jeff Yurek: Thanks for coming in tonight, and for your testimony. Do you have lists of the hospitals in other provinces, the percentage of those that are providing MAID, other than in Quebec? Because you said it was everyone, but Alberta—

Ms. Shanaaz Gokool: No one is tracking this. Alberta is the only province outside of Quebec that actually has a system in place. If you want to have an assisted death and you're in Covenant, which is the only palliative care provider in Edmonton, you have to be navigated out of the system for a day—they have health navigators that transfer the patient out for a day—where you can go and have your questions asked, you can make the request, you can have the assessments. Then you're transferred back to the hospital until the time that you receive assistance in dying, when you're transferred out again.

I spoke to Jan, who is Ian Shearer's daughter. She lives in Alberta. Her father was in BC when this happened to him. She said there's no way he would have been able to tolerate the transferring in and out of systems in order to be able to access what is now a legal right.

No one is tracking this, but we do know that many hospitals and hospices right across the country are opting out altogether, and no one is tracking it.

Mr. Jeff Yurek: Do I have time?

The Chair (Mr. Monte McNaughton): Yes.

Mr. Jeff Yurek: Have you any data in Ontario that tracks the availability of hospices and/or palliative care teams in hospitals? Do you have that data available?

Ms. Shanaaz Gokool: In terms of where palliative care is being offered?

Mr. Jeff Yurek: Accessibility, yes.

Ms. Shanaaz Gokool: No, I don't have that data. I think what we do know—and what we do need more clarity on from hospices and palliative care units is who are the ones that want to opt out of providing assistance in dying and who aren't. That's not very clear, and that's the real piece of information that we need to know, to understand how accessible medical aid in dying will be.

Mr. Jeff Yurek: Is that it?

The Chair (Mr. Monte McNaughton): All done. Madame Gélinas.

M^me^ France Gélinas: Thank you so much for coming. Very quickly: I had a case in my riding where this gentleman wanted MAID. We could only find one physician in Sudbury, who did the first assessment. We could not find a second assessment. This 1-800 line that you call is a joke. Finally, almost a week later, we got somebody in London who would do an assessment over video conference, if and when we could bring the patient to a video conference room.

Are we the only one whose system does not work at all? I represent the North East LHIN. There's one physician in all of the North East LHIN who has put their name forward on this 1-800 number.

Ms. Shanaaz Gokool: So there's a real problem with access as it relates to referrals and just finding physicians. Ontario is the only province that has a 1-800 line for providers to call if they conscientiously object. But as you just said, the process is a bit of a joke. Now, the process and the requirement from the College of Physicians and Surgeons of Ontario for an effective referral is currently being challenged in court by a coalition of Christian dentists and doctors who don't want providers to even do that. So when you've got the issue of difficulty finding providers—and that is a problem.

I do imagine, over a period of time, as this practice becomes more normalized and more doctors and nurse practitioners are familiar, then hopefully there will be a larger body of providers across the province.

But when you also have the double whammy of people who are in hospitals who don't want to answer your questions or give you an effective referral, let alone provide assistance in dying on their premises, then you've got a real problem.

So you've got a problem with not having enough physicians, and then you have the problem of where people are going to go when they're in facilities that just say, "We don't want to touch this," on conscience grounds.

The Chair (Mr. Monte McNaughton): We're going to move to the government now, and Mr. Fraser.

Mr. John Fraser: Thank you very much for being here today and for all your work, and the work that you've done with regard to the court decision.

I don't think, if I was a practitioner, that I could participate in it. I understand—and I'm glad you mentioned two rights, because you're trying to balance two sets of rights. What we have here is something that's relatively new. What I firmly believe is that we have to be careful not to take hardened positions, because this will evolve. There's a risk of hardened positions creating more harm than both sides want to have happen. I wanted to express that.

My mother's a nurse. She's in her 80s. I asked my mom. I said, "Well, Mom"—and she's Catholic. I don't think this is just about Catholics. There are a lot of people who have a conscience who believe that they could not do this. I said, "Could you do this?" She said, "Well, no, but there are extreme circumstances."

What she was saying to me was, "I have no proximity. You're asking me a question to which I have no proximity. So I'm giving you an answer that I can give you right now, but I may give you a different answer at another time, when confronted with something else."

I think, as a society and as a province—I know that in my region, the Champlain region, they're working very hard, and they've had success with making sure that things are organized. I think that we have to recognize that problem of proximity, not just individual proximity but proximity as a society, because it's new and it's going to evolve.

What I really wish we'd do—because this is about choice. The Supreme Court decision is about choice. But

in order to have choice, you need choices. The reality is, more people need access to those choices—quality palliative care—so that they can have a real choice—

The Chair (Mr. Monte McNaughton): Mr. Fraser, that's all the time—two minutes.

Mr. John Fraser: Thank you.

The Chair (Mr. Monte McNaughton): Thank you very much for your presentation.

Ms. Shanaaz Gokool: Thank you.

ONTARIO MEDICAL ASSOCIATION—SECTION ON GENERAL AND FAMILY PRACTICE

The Chair (Mr. Monte McNaughton): We'll now move to the Ontario Medical Association—Section on General and Family Practice. I think the doctors are in the house.

You'll have nine minutes for your presentation. If you would state your names for Hansard and then begin.

Dr. David Schieck: My name is Dr. David Schieck.

Dr. Ross Male: My name is Dr. Ross Male, from Brantford and Paris.

Dr. Allan Studniberg: My name is Allan Studniberg, from Toronto.

Dr. David Schieck: Thank you, Chair. As I've stated, my name is Dr. David Schieck. I am the chair of the OMA Section on General and Family Practice, and I'm a family doctor from Guelph.

With me here tonight is Dr. Ross Male, the vice-chair of our section and a family doctor from Brantford, and Dr. Allan Studniberg, the chair of our health policy committee and a family doctor from here in Toronto.

We are all comprehensive care family doctors. We appreciate the opportunity to address the committee regarding the proposed legislation.

The Section on General and Family Practice represents over 12,000 family doctors in Ontario. Every day, Ontario's family doctors provide care to over 155,000 patients in our offices, in patients' homes, in hospitals and emergency departments, in retirement homes, long-term-care facilities and in hospices. This is what family doctors do every day.

Family doctors provide the best value for care in the system. Of all the sectors in our health care system, family doctors have the broad front-line experience and insight to best inform ways in which primary care can truly be strengthened in Ontario.

That is why there is a deep concern amongst Ontario's family doctors that a bill of this magnitude has been brought forward without tapping into our expertise through meaningful, broad-based consultation that is necessary to successfully deliver on the promise of strengthening primary care.

Dr. Allan Studniberg: I would like to continue by stating that we have serious concerns around the redundancy of several of the features of this proposed legislation.

We already have rigorous oversight by our regulatory college, and there are accountabilities for care built into our current contracts that most family doctors in this province are already signatory to with the ministry. Family doctors already report on their practice profiles, and quality measures are already available and reported on through the system. All of these aspects of this bill are duplicative and completely unnecessary.

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In addition, we anticipate a real struggle in the implementation of this bill, if passed as currently proposed.

As individual practitioners, we are small businesses. We have to run our businesses efficiently. The increased bureaucracy and oversight that is being proposed through this bill does not work for family doctors. In this time of limited resources, family doctors do not need added layers of bureaucracy or administrative burden. What family doctors really need is time with our patients to provide that personal care that is the essence of family medicine and that supports the one-to-one relationship that we have with our patients. We need access to more of the necessary resources that allow us to provide effective, efficient care to our patients. Bill 41 provides no additional resources

Dr. Ross Male: Chair, my name is Dr. Ross Male, and I would like to propose an alternate approach to strengthening primary care.

Rather than apply a command-and-control, top-down approach to the administration of primary care that is delivered through formal sub-LHIN structures, family doctors have other solutions. These solutions are based on a real culture change that comes from a grassroots, bottom-up approach to care. We see this exemplified through the idea of communities of practice.

Communities of practice are groups of people who share a concern, a set of problems or a passion about a topic, and who deepen their knowledge and expertise on an ongoing basis. Real-life examples of communities of practice already exist in family medicine throughout Ontario, like where I practise in Brantford.

When our local hospital department of family medicine dissolved, as more and more family doctors gave up their privileges at the hospital, we still saw a need to collaborate as family physicians in the community, to solve our problems. Consequently, we formed a community department of family medicine, which meets regularly four times a year. It includes members from each of the main family practice groups in the community from a variety of practice models.

Together, we have addressed issues that will improve the care that we can give to our patients, which is our underlying goal. These issues include hospital-specific issues like improving hospital-physician relationships, improving the quality of the hospital discharge process, and effectively transitioning our patients between the community and the emergency department.

We're figuring out how to better connect the local walk-in clinics with the community family physicians. We have discussed problems in access to specialized

services and specialist services, such as outpatient pediatrics, psychiatry, and pre-op assessments.

We have an educational focus and have developed full-day educational symposia. We have also created our own website for resources for referrals. We have participation from our local LHIN clinical lead, when requested, and she has helped us develop processes to access resources outside our area.

The Brantford experience demonstrates that an organic, largely informal organization of family doctors has a far greater chance of success in addressing population health issues in a defined community, because the members of our community of practice share a common goal and a commitment to each other, and it's not forced or directed. It also does not cost as much as formal structures, because it's driven by our passion for caring for our patients. Our reward is greater innovation that's fuelled by quick diffusion and adoption of ideas, which also includes more efficient practice.

I now turn it back to Dr. Schieck.

Dr. David Schieck: Chair, the family doctors of Ontario oppose this bill.

No one wants a better health care system more than the hard-working, dedicated family doctors in this province. It's better for our patients and it's better for everyone working in the system. But we believe that we would be in a very different place right now if there had been more meaningful consultation with the real experts in this area: the front-line family doctors in this province and their patients.

Family doctors are discouraged, and they are finding it harder and harder to do their jobs. Family doctors need to have access to the resources necessary to do their jobs. This bill does not offer those resources.

Family doctors need and want, more than anything, to operate in an environment with fair and reasonable expectations. This bill promises authoritarian, heavy-handed, top-down oversight and bureaucracy that will undermine local efforts.

We believe in collaboration. This is not collaboration. We need a culture of care, not a culture of process.

Chair, you will be receiving our written submission, which outlines several specific areas of concern that our section has identified with this bill. Along with these concerns, we have included our proposed alternatives for consideration, as well as proposed amendments to the bill. We hope that you and your committee will give them serious consideration.

Thank you very much for your time this evening. We are happy to take questions.

The Chair (Mr. Monte McNaughton): Excellent. Thank you very much. We'll begin with Madame Gélinas of the third party.

M^me^ France Gélinas: You are the first group of physicians that comes in front of this group and that does not ask us to simply scrap it. You're going to come forward with this community-of-care model that you will share with us. That's the first group. I was surprised.

On page 2, you made clear the redundancy of what they're asking you to do. You're not against the reporting; you're more against reporting it twice. If we were to make this information, which you already share with the ministry in your contract, available to the LHINs, would you then be more open to this?

Dr. David Schieck: A lot of that information that you're referring to is already publicly available to whoever wants it.

M^me^ France Gélinas: So we don't have to make it available; it's already there?

Dr. David Schieck: If my LHIN wants to find out all of that information about me, they have access to the CPSO, our regulatory college, that provides very good oversight for the profession.

There are immense quantities of data available out there, through Health Quality Ontario, on my practice. If my LHIN wants that data, it's available through Health Quality Ontario. It does not need to be baked into legislation to be available to help things work better in our communities.

M^me^ France Gélinas: Understood.

When you talk about the government not having worked with family physicians, was your group ever consulted before Bill 41 came out?

Dr. David Schieck: Specifically, the Section on General and Family Practice was not consulted—

The Chair (Mr. Monte McNaughton): Sorry; that's all the time.

We're going to move to the government, and Mr. Fraser.

Mr. John Fraser: Thank you very much for being here, Dr. Schieck. It's the second time we've seen each other, so we won't go back into what we discussed in the last line of questioning.

Dr. David Schieck: I would love to have a conversation off-line with you again.

Mr. John Fraser: Any time.

Stewardship is a really big part, I think, of this bill. I think it's not written in the words, but that's the critical component of making local health decision-making stronger. I can understand concerns when you have change. But I do want to say that you gave me an example in Brantford of what you're doing there. If it happened everywhere else, we probably wouldn't be sitting around this table, having this conversation.

I'd just like to kind of open your minds to the fact that that's what this bill does. It permits that. I know that there are some concerns—I think we talked about it—in terms of information and around redundancy that I think you'll see addressed.

I really, firmly believe that we need to strengthen that local decision-making.

To be really fair: Inside your own organization, there are issues of relativity that go unaddressed, which makes it really difficult to provide the kind of resources that we want to. That's not a question, so you don't need to respond to that, but I'm just going to say that out loud, because I think that that is a critical thing. If we're looking at stewardship in the system, we have to look at everything.

I very much appreciate all the work that you do. I want to thank you very much—

Interruption.

Mr. John Fraser: That wasn't somebody pounding—okay. I thought I just got the gavel.

I thank you very much for bringing up that example. That's what this bill is about. It's trying to infect smaller cells so that we can get past that point of inertia, so that it goes throughout the whole system.

I want to thank you very much for being here tonight.

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The Chair (Mr. Monte McNaughton): Thank you very much. That's all the time from the government.

We'll move to the official opposition and Mr. Yurek.

Mr. Jeff Yurek: Thanks for coming in today. I appreciate the OMA coming forward. We'll let you respond.

A couple of things: It's unfortunate that they didn't consult with you. That's terrible. Hopefully, they'll go forward and reach out to OMA again. I got mad. They're blaming OMA for this, and I don't see that as the situation.

We agree with you that it's a power movement up towards the LHINs, and it doesn't enable the health care provider to do the work. Your model in Brantford shows that.

How much more can we enable the health care providers to work around the patient to create the system we need? Do we need the bureaucrats telling the doctors how to create a health care system?

Dr. Ross Male: I don't think you do, because if you just seed the idea with the doctors—we want to do this for our patients. It's more a case of enabling it as opposed to forcing it. I've seen it in other areas, in other LHINs that are adjacent to us, where this sort of thing is growing up.

The idea is to support that and enable it and allow ideas to diffuse. Communities of practice can be community-based, but you can also have them province-wide at a different level. The province has done different things to try to help diffuse things. Health Quality Ontario does a good job of that. There are already a lot of ways of trying to encourage that.

A lot of this came out of the Baker-Price report. We know that when they put that report out, they did think that the next step would be a broad-based consultation around the ideas, to firm them up. That has never happened.

Mr. Jeff Yurek: No. I agree. It's like missing the main ingredient in baking a cake. It's not going to come out that great at the end of the day.

The government has made mention of having an advisory council made up of health care professionals as optional. Do you think making that mandatory might actually improve what's going to go wrong with the system?

The Chair (Mr. Monte McNaughton): Sorry, that's all the time for your presentation. Thank you very much for coming this evening.

ONTARIO PERSONAL SUPPORT WORKER ASSOCIATION

The Chair (Mr. Monte McNaughton): We'll now call upon the Ontario Personal Support Worker Association.

Please you'd say your name for Hansard, and you'll have nine minutes for your presentation, beginning with questions from the government.

Ms. Miranda Ferrier: Okay; great. My name is Miranda Ferrier. I'm the president of the Ontario Personal Support Worker Association. This is my colleague Kathleen Scott, who is the vice-president of OPSWA, as I will refer to it, because otherwise it's a really long name.

I want to thank you, Mr. Chairman and committee members, for having us here today. We are the professional association for personal support workers in the province of Ontario. We currently represent over 22,000 PSWs. Our membership is specialized in the sense that they are all fully vetted personal support workers. All of our PSWs go through national criminal record checks yearly, and upon becoming a member, their credentials of schooling and identification are verified. OPSWA members also carry a photo ID that identifies them as a verified PSW that is fully vetted and trustworthy.

We're here today, obviously, to speak to you regarding Bill 41. We bring you not only our opinion and observation as the professional association for PSWs, but also insight from the front line, from the personal support workers, our membership.

The act is good, but it is lacking more specified structures, or guidance, for the personal support workers in relation to standards of practice, scope of practice and oversight.

In Patients First, the PSW is being expected to perform the majority of care. They are the largest number of front-line workers in community and home health. PSWs are being expected to perform specific aspects of care, such as pain management, food consumption and behavioural symptoms. Most of the mentioned aspects are not taught in the PSW curriculum, or at least not taught to full capacity, as the PSW course is actually viewed as a novice course.

More and more people are staying home. PSWs are typically the front-line worker they see or deal with first, and typically the last. PSWs are being expected to take on this mammoth responsibility, but with no policies or standards in place, or no specific training.

Our membership has been extremely vocal in wanting more specific training. Because of this growing demand, the association is specializing PSWs in certain areas, such as palliative care, dementia, mental health and autism, just to name a few. We have partnered with the Home Hospice Association, and we're in talks right now with the Centre for Addiction and Mental Health. We believe that by specializing the PSW, we'll be able to create a more unified team approach to home care. If they all speak the same language, communication will increase and quality of care will enhance.

We believe, as I know the Ontario government does, that quality of care is extremely important. Working in community or home care, the front line is not supervised, and PSWs are the most consistent worker in the home. PSWs are not regulated or governed, therefore not given a set scope of practice or standards of practice that they all must adhere to. We believe that these components will help PSWs perform their duties more efficiently and safely. Personal support workers need to know what they can and cannot do. There is a lot of confusion in the field, because there is no set anything. Therefore, it's putting society at risk.

At the association, we have a scope of practice and standards of practice, plus a code of ethics, that our members have to abide by. We think that if Bill 41 were to adopt our suggested system, the PSWs and those in their care would benefit greatly. One of the many reasons why the PSWs and the public would benefit greatly from adopting our system is that all OPSWA PSWs carry an ID badge, as I mentioned before. These badges are done through Sterling Talent Solutions. We'll refer to them as BackCheck, because most people know them that way. On this ID badge is the PSW's picture; the date of expiration, as it is done yearly; their name; their designation; their registration number with the association; and a serial number. At the top of the badge is a website. A client, a member of the public or an employer can go to this website, input that serial number, and that PSW should pop up.

So one of the ways we feel that the OPSWA system can truly help is to show who will be knocking on the client's door before they even get there. This provides safety, accountability and legitimacy to both the PSW and the client, and provides the oversight which is desperately needed in community home health.

This badge system would also enable the Ontario government to track the personal support workers in their jobs, providing much-needed accurate data for the system.

In one of the sections in Bill 41, it was stated, "The local health integration network may appoint a health service provider supervisor to exercise the powers of the governing body of certain health service providers if it considers it to be appropriate to do so in the public interest."

We believe that oversight and accountability are extremely important. Currently, if a PSW were to be accused of abuse, theft or neglect, they can leave their job, they can go down the street and they can get another job. There is no entity out there tracking the masses and ensuring that our most vulnerable are safe. There is no entity that ensures that when a member of society has a PSW, due to injury, illness or disease, that PSW is a trained, thoroughly vetted professional, accountable to their governing body.

As the only professional association for personal support workers in Ontario, we want to be that governing body. We will work with the Ontario government to provide PSWs with the necessary training, oversight and accountability. We can provide a scope of practice, standards of practice and a code of ethics. We already have a complaints and discipline committee set up that is overseen by a committee separate from the association. We believe that with governance, not only will PSWs benefit, but so will our most vulnerable.

Let us help you put trust back in the system. We are invested in Ontario's PSWs and in our health care system.

Thank you very much for letting us give this speech today.

The Chair (Mr. Monte McNaughton): Thank you very much. We'll move to the government and Ms. Kiwala—sorry, Mr. Anderson.

Mr. Granville Anderson: See, you're getting two of us.

Thank you for being here, and for your support of this bill—mind you, with amendments, of course.

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I have had experience first-hand with the quality of work of PSWs, and I cannot thank them enough. I believe they're undervalued, and they're very important to our society, especially to our most vulnerable.

I don't know if there are instances of abuse. I haven't really heard of any. But my dealings with PSWs have been excellent and first-rate, and I know a number of people who have had PSW services, whether it's private or government, and the quality and the people are just wonderful. They're wonderful people.

Ms. Miranda Ferrier: Good.

Mr. Granville Anderson: Having said that, if the Patients First Act is passed, all employment contracts at the CCAC would be transferred to the LHINs, so that's removing one level of government and bringing more accountability, and that's what the public wants: less bureaucracy and better services.

How can we work with your members to ensure these transitions are as smooth as possible?

Ms. Miranda Ferrier: Transparency, I think. Being honest with the PSWs. Maybe communicating directly to the front line, as opposed to—a lot of times, it doesn't go straight to the front line. It goes above their heads, and it doesn't make its way down.

I think our members need to see that there is a trust in them, especially with this whole changeover from the CCACs to the LHINs.

I happen to come from the Waterloo region, where they actually did a pilot project on that. There was a lot of confusion and disregard for the front line.

Mr. Granville Anderson: Ms. Kiwala, you have a question?

The Chair (Mr. Monte McNaughton): Actually, the two minutes are up.

Ms. Miranda Ferrier: Oh, jeez. Okay. Sorry.

The Chair (Mr. Monte McNaughton): We're going to move to the official opposition, and Mr. Yurek.

Interjections.

Ms. Miranda Ferrier: Thank you.

The Chair (Mr. Monte McNaughton): Mr. Yurek.

Mr. Jeff Yurek: Thanks very much, Chair. Thanks, guys.

Laughter.

Mr. Jeff Yurek: I see what you're saying here. What happened to the PSW registry? I know it got cancelled. Were you involved with helping out with the PSW registration?

Ms. Miranda Ferrier: No, I was not. We sat on the steering committee in the beginning, but when it took a different path, shall I say, or direction than what we intended for PSWs, we stepped back from the PSW registry.

Mr. Jeff Yurek: But you're kind of proposing a college-like system without being a college—

Ms. Miranda Ferrier: A college-like system—not regulation, because PSWs are non-medical, and regulation costs a lot of money. So with governance, it would be set up very similarly to the trade-school model—if you look at the Ontario trade schools—in the fact that we would self-govern.

Mr. Jeff Yurek: Okay. With regard to respect of the front-line health care professionals, like PSWs, I've had many discussions with PSWs in my area. You know, the hours, when they're expected to be somewhere—five places at once—and 100 kilometres apart from the next location—

Ms. Miranda Ferrier: They have to teleport, yes.

Mr. Jeff Yurek: I find that really difficult. I don't see a lot of bureaucracy being cut back at all with this merger going on. We see the CCACs already keep 39% of the dollars for administration; it doesn't reach you. What can we do to try to get more money to the front-line health care workers like the PSWs, who people are demanding at their house?

Ms. Miranda Ferrier: That's a really difficult question to answer. How to bring the money down to the front line?

Mr. Jeff Yurek: Yes.

Ms. Miranda Ferrier: I think the money needs to make it there first. A lot of PSWs are not seeing the wage enhancement that did come into play and that was promised—unfortunately.

Mr. Jeff Yurek: Are their hours cut back?

Ms. Miranda Ferrier: Their hours have been cut right back. We had one situation where we actually did take—

The Chair (Mr. Monte McNaughton): Sorry, I have to cut you off. The two minutes are up.

We're going to move to Madame Gélinas from the third party.

M^me^ France Gélinas: It seems like everybody is in agreement with what you're putting forward. So what's the holdup? Why aren't we moving toward a self-regulation type of system with the ID badge that you are putting forward? Where's the holdup?

Ms. Miranda Ferrier: I'm not sure that there is a holdup. We have talked with the minister's office, and we continue to talk to the minister's office. I think any more support that we can receive would be very much appreciated toward this initiative. We think that having this badge system would definitely support the home health sector and enable more safety, and efficiently and adequately—quality of care will increase, right? Then, with scope of practice and standards of practice, everything will just be elevated in the profession.

M^me^ France Gélinas: Were you told that we needed legislative change in order for this to happen, or could it happen through regulation?

Ms. Miranda Ferrier: We're not certain on exactly how this would happen because it's a trade-school model, so I believe that possibly it would just have to be said that it would happen. That's kind of what we've heard. We would want legislative to come in so that it would be secure, but other than that—

M^me^ France Gélinas: So you see Bill 41 as an opportunity to move it forward as amendments to the bill?

Ms. Miranda Ferrier: Yes. For the home health care sector, yes.

M^me^ France Gélinas: Okay, thank you.

The Chair (Mr. Monte McNaughton): Great, thank you very much. Thanks for being here this evening.

TORONTO NEIGHBOURHOOD CENTRES

The Chair (Mr. Monte McNaughton): I'd now like to call upon the Toronto Neighbourhood Centres for their presentation.

Good evening.

Mr. Rob Howarth: Good evening.

The Chair (Mr. Monte McNaughton): You have nine minutes for your presentation.

Mr. Rob Howarth: Wonderful.

The Chair (Mr. Monte McNaughton): If you would just state your name for Hansard and then begin.

Mr. Rob Howarth: Thank you, Mr. Chair and committee members. My name is Rob Howarth, and I'm speaking on behalf of the network of 30 multi-service non-profit organizations in Toronto called the Toronto Neighbourhood Centres. I'm requesting amendments to Bill 41, the Patients First Act.

As multi-funded community hubs and independent non-profit charitable organizations, our member agencies are alarmed by the draft provisions in section 21.2 of this bill, and all of my comments are related to that section.

This section outlines the powers of local health integration networks to appoint a "health service provider supervisor of a health service provider to which it provides funding when it considers it to be appropriate to do so in the public interest."

We believe that the powers outlined in the proposed legislation present three challenges. First of all, they contravene other regulations and statutes related to the governance of non-profit charities. Secondly, they're unworkable from a practical perspective in the case where LHINs funding represents only a portion of a health service provider's assets and funding contracts. Finally, they do not contain safeguards typical of comparable provincial acts.

We are requesting that you amend Bill 41 to exempt multi-funded organizations from the provisions outlined in section 21.2, and clarify that a LHIN-appointed supervisor is empowered to direct only those resources and programs that are LHIN-funded.

We believe that such amendments are needed to safeguard the integrity of Ontario's community-based non-profit organizations, confirming their status as autonomous contributors to community well-being, instead of treating our province's non-profit sector as a mere extension of government.

Privately incorporated non-profit charitable organizations are required to have a member-elected board of directors in place in order to comply with both the Ontario Corporations Act and the regulations governing charitable status under the Income Tax Act. We are concerned that the introduction of a LHIN supervisor raises complicated issues regarding board responsibility and liability and will impact funder and donor confidence to the point where it may compromise an organization's viability and community accountability.

A number of our member organizations do not receive 100% of their funding from the Ministry of Health via the LHINs, but are funded by numerous governments, as well as by privately fundraised donations. For some, the proportion of LHIN funding may represent less than 10% of a multi-million dollar annual operating budget.

If a LHIN-appointed supervisor was given control over an organization's privately fundraised dollars, as well as stewarding all of the organization's federal and municipal government service agreements, we believe this would be a major concern for our other funding partners and that a LHIN-supervised organization might be in default of these diverse contractual obligations.

It is for these reasons that again we are requesting you amend section 21.2 of the bill to specify that the LHIN-appointed supervisor is empowered to direct only those resources and programs that are LHIN-funded.

We would also recommend the following specific changes to section 21.2 so that that the provisions for a LHIN-appointed supervisor are more carefully defined. There are three.

We would suggest that you define more specifically, through guidelines or regulations, the conditions under which it would be in "the public interest" for a LHIN to appoint a program supervisor. We can imagine many conditions in which it would be in the public interest, but we think those should be specified.

Secondly, we believe that section 21.2 should include the requirement for ministerial and cabinet approval before the LHIN may appoint a program supervisor. This is currently not provided in the draft legislation.

Thirdly, we believe there should be some mechanism for a community-governed non-profit to request a review or appeal in terms of the appointment of a program supervisor.

We note that such provisions and safeguards are included in other provincial acts, such as the developmental disabilities act from 2008 and the Long-Term Care Homes Act from 2007.

Thank you very much for considering our proposed amendments. I look forward to your questions.

The Chair (Mr. Monte McNaughton): Great, thank you very much. We'll begin with the official opposition and Mr. Yurek.

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Mr. Jeff Yurek: Thanks for being here. You're not the first to say you have problems with a section of the bill. Many have come forward with proposed amendments. I'm hoping it's a trend that will be vigorously debated in amendments—and your ideas taken forward for concerns.

I would imagine if the LHIN-appointed supervisor took over your board, your volunteers who fundraise might view it as an opportunity to disappear on you. Do you have that fear, that your fundraising efforts might disappear?

Mr. Rob Howarth: It could definitely impact fundraising efforts. There would be questions about who actually controlled the organization. But I think it would also impact just the volunteer commitment of community leaders in terms of their commitment to steward these organizations. It's kind of a slap in the face to their ongoing commitment to these organizations.

Mr. Jeff Yurek: It's interesting that you brought up maybe the contravention of the Corporations Act and the liability on your board members.

Mr. Rob Howarth: Yes.

Mr. Jeff Yurek: Do you have any further information? I don't know if you have access to—

Mr. Rob Howarth: We haven't run this through lawyers at this point, so, no, I do not.

Mr. Jeff Yurek: That would be something to—

Mr. Rob Howarth: These are concerns, but I don't have more details.

Mr. Jeff Yurek: Okay. I appreciate your amendments. Hopefully, we'll be putting them forward and seeing what transpires on clause-by-clause day.

Mr. Rob Howarth: Thank you very much. I appreciate it.

The Chair (Mr. Monte McNaughton): Any further questions? We'll move to Ms. Gélinas.

M^me^ France Gélinas: I too want to thank you for bringing this forward. I can guarantee you that the NDP will be bringing those amendments forward.

My first question is, did you know that this was going to be in Bill 41? Did you have a chance to talk—

Mr. Rob Howarth: No, we did not. This was a surprise to the secretary—at least to my knowledge, and with our partners, the Ontario Nonprofit Network. We were not aware that this was going to be a provision in the bill.

M^me^ France Gélinas: Did you have a chance to influence the bill? Did they reach out to you before they brought the legislation out?

Mr. Rob Howarth: Not to my knowledge.

M^me^ France Gélinas: No, eh?

Mr. Rob Howarth: No.

M^me^ France Gélinas: Okay. We will try really hard to make those changes. If those changes were not to be made, if they turn them down—they have a majority Liberal government. If they turn them down, how important is it that the bill be held back? You will let it go or—

Mr. Rob Howarth: Well, I think it is a significant issue around the structure of the non-profit organizations in the province. I think we'd have to be asking whether we would take similar steps with for-profit corporations and take them over through legislation as well, or control them through an appointed supervisor. I'm not sure it's a good relationship between the government and the sector. I think it's pretty significant.

M^me^ France Gélinas: Agreed.

My last question is, other not-for-profits have talked about the terminology "agency" now being open to for-profit. Is this a worry of yours? Is this something you have flagged?

Mr. Rob Howarth: Yes. We do share that concern, and as non-profit providers we would prefer, in terms of serving the public interest, to keep as much as possible in the non-profit sphere.

M^me^ France Gélinas: Thank you.

The Chair (Mr. Monte McNaughton): Great. Thank you very much. We'll move to the government. Ms. Kiwala.

Ms. Sophie Kiwala: Thank you very much for being here, Mr. Howarth. It's a pleasure to hear you speak today.

We have a community health centre in Kingston which has the very same concept of delivering care in the community as you're discussing: local care, bringing all kinds of different health providers into the same place, reinforcing the neighbourhood, exactly the same priorities.

We did do consultations, by the way, with the KCHC in our community. They were certainly present when we did at least one consultation, and I think they did another one as well with the local LHIN.

I'm wondering if you could speak to how your members have seen health inequity across the system and the impact that subregional planning could have to address the local needs of Torontonians—in, like, 30 seconds.

The Chair (Mr. Monte McNaughton): Almost a minute.

Mr. Rob Howarth: Okay. I don't think I can speak to that, I'm afraid. Our member agencies, some of whom may have presented, would be much more able to speak to the health inequities and the planning processes.

Ms. Sophie Kiwala: Okay. It certainly was something that was in discussion in my community, and it was something that the local health centre was concerned with.

Mr. Rob Howarth: I think the health centres have a lot of expertise in that area, and I just wouldn't speak on behalf of them. We have—

Ms. Sophie Kiwala: But for yourself, for Toronto, within your own area of responsibility in Toronto.

Mr. Rob Howarth: There are issues of health inequity in communities across Toronto. There are also issues in terms of how resources are distributed through the health care system to address that, but I couldn't speak in detail about that.

Ms. Sophie Kiwala: Okay. Thank you very much for being here today. It was a great deputation.

The Chair (Mr. Monte McNaughton): And right on time, too. Thank you very much.

Mr. Rob Howarth: Thanks very much.

The Chair (Mr. Monte McNaughton): Thanks for coming this evening.

INSTITUTE OF CANADIAN JUSTICE

The Chair (Mr. Monte McNaughton): I will now call our last presenter of the evening: Institute of Canadian Justice.

Good evening. You'll have nine minutes for your presentation, followed by two minutes of questioning from each party. If you would just say your name for Hansard, then you can begin. You have nine minutes.

Mr. Gerald Parker: My name is Gerald Parker. I am the executive director of the Institute of Canadian Justice, a non-partisan, no-nonsense seeker of the public's interest, safety and health since 2009. Prior to 2009, we were accessibility pioneers that helped make hospitals, infrastructure, events, facilities and services safe for people with disabilities, seniors and veterans. So we know a little about health care and people with disabilities.

First of all, I want to thank you for your time and important attention to these most quintessential discussions that will enable or, as is the case, disable the universality and sustainability of safe health care in Ontario and across Canada.

I am here to speak about the importance of the ombudsman's independence, the educational role that they need to play and the funding and factoring that they need in order to save lives and billions. As we said, and as Dr. Bell and Minister Hoskins said at Health Quality 2016 just a few weeks ago, to be the best and nothing less and to ensure patients are always considered first—patients first: patient-centred care.

As a person, a professional, a patient, a parent, a disabled Ontarian and a caregiver, I have been in this room and before multiple standing committees over the years. I have heard the nightmares you have heard for over 30 years. We have worked very hard to make Ontario better, safer and healthier. I've also marched with my kids out front, snuck a few cheeky claps in the House and helped to resource game-changing public policy, like this can be. We, and also you, can help save lives and billions in our work here today.

Like then, we are here to ensure that universality, sustainability and the public's interest are arrived at in a more robust and well-understood manner. We are here to provide some additional insight and solutions and to do

right by us all. "Compromise" is not a dirty word if done with the right people at the right time for the right reasons. Tonight, I will be asking you to do exactly that: to see the common good for our loved ones and our health care system and the importance of the public's trust when very bad things happen as a result—much like was the case when we were before Bill 181, when we pleaded that health care and police services boards be not exempted from the Ombudsman's full purview, and righteously intended all eyes and ears and the smart-with-heart engagements that they do. It did not happen then, and this round will simply continue, the bell not rung until it's done. Patient safety, universality and public trust are too important to do otherwise.

So thank you for Bill 41, the act for patient-centred care. It's vital. It's a critical exercise, and this act is necessary to ensure, again, the safety, sustainability, universal services, and most importantly, to such ends, the well-resourced and educated prevention of injury and fatalities in Ontario. This is a discussion about life and death, about our loved ones and universality in Canada.

Let's ask some foundational questions here: What do we have if we don't have our health? What do we have if we do not have a quality of life? What do we have when public funds and policies do not meet our needs and quality of life? Well, as Dying With Dignity said before, and others before you, it is increasing demands for premature death right now. It has gotten so bad for some citizens and even caregivers. Demanding premature death, the warehousing and sedation of seniors, addiction and the opioid pandemic: They are all connected—because the suffering is chronic and acute, the destitution of our families is rampant and, yes, we have the lowest level of long-term-care beds in the OECD.

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As a prescription adherence report by the Canadian Medical Association's journal says, people are making decisions, as our hashtag says, between cat food, prescriptions and—as CBC's Marketplace and my colleagues said on Friday night, God bless them—between cat food, prescriptions and hospital parking. Six per cent of a person's monthly income is spent in one day at a hospital in this town. It's wrong, especially when they're predatory. So Sunnybrook had it coming to them. But the importance here is, what's the predication of that business? What's its business model? Who are they serving, or who are they not serving? The point is that that hospital has known about this for over 20 years. There was no one there advocating a solution of this issue. Christine Elliott, the Patient Ombudsman, should have, and needed to be there.

These, as I've just spoken, are all breaches of the Canada Health Act, the charter of human rights, the ODA, the AODA and, yes, the common sense and decency of the sick, the dying, the destitute. The law is not being respected, and it needs a real advocate.

All of these issues need an independent ombudsman, specifically, patients first—sorry, I skipped ahead just a tad. "Patients first" is a mantra, and as such, for patients, family and caregivers, primary last-ditch advocates, it needs a bark, a bite and dinner. Indeed, the saying that all other independent officers of the Ontario Legislature get—why the health services so vital and close to us all are even considered to be exempted or provided preferential or lesser provisions of accountability and efficiencies—is just simply, well, wasting money.

Recommended suggestions and amendments—I'm wrapping up. All hospital and patient advocates should be hired, resourced and triangulated as the Patient Ombudsman's employees and processes. Corporate risk managers are exactly that, and not patient-centred, care-solutions-orientated, but rather, liability deflectionists and obstructionists. Patient advocates need independence and resourcing as well if universality, sustainability and public trust are to be arrived at and maintained.

Secondly, the Patient Ombudsman has to be independent, as other Ontario legislative officers are. Fair is fair. We do need a watchdog in the trenches with capacity, with very public accountabilities—bark, bite, rather than a wag and a belly rub in the minister's office. And may I add, as you heard this morning, our Patient Ombudsman, Christine Elliott, is no lapdog. Sustainable resources, non-politicized funding, and accountabilities and independence: That's recommendation number two.

Recommendation number three: acute trends in education capacity. Being in the trenches comes with benefits beyond the daily shell shock of devastating stories. You know the collateral damage and life-saving and cost-effective solutions before anyone else does. Examples: the Auditor General's winter maintenance report—the increase in the winter fatality rate; increased PTSD and injury of our first responders; occupational obligations accordingly; catastrophic coverages down now to $86,000 that are going to bleed out in our hospitals and ruin our families; or the efforts of Bill 9 to stop discriminatory treatment of post-stroke patients who unluckily, between the ages of 19 and 64, if they happen to have a stroke—the ageism and discriminatory practice puts them out on the sidewalk.

These are things that an advocate at the highest level can assist, trend and remediate. It is a cost-efficiency. It's about saving lives and billions of dollars so that we can continue to reinvest it in health care and maintain its universality, sustainability and safety. It's a no-brainer. Public education and proactive trend identification save lives and billions. That's my third.

My fourth and last: The LHINs and all health services need to be under the Patient Ombudsman in order to save lives and billions. Fragmentation doesn't work; any smart business person will tell you that.

In conclusion, as our Twitter hashtag says, we are all about saving lives and billions. An ombudsman's independence is good medicine. An ounce of prevention is worth a pound of cure every time. The reality is this: It's about our family, our loved ones, the most precious members of our communities, our moms, dads, sisters—

The Chair (Mr. Monte McNaughton): Thank you. Sorry to interrupt. That's all the time we have.

We'll move to Madame Gélinas for questions.

M^me^ France Gélinas: Thank you so much for—

Mr. Gerald Parker: I have one paragraph left.

M^me^ France Gélinas: Go ahead. I'll give you my 15 seconds.

Mr. Gerald Parker: Thank you.

This is about you and me, and not us and them. It's as human as it gets when your loved one dies or suffers from preventable circumstances—circumstances that say, "Do no harm and advocate for the patient above all." Patients come first and they need a timely, well-resourced, well-educated and independent officer of the Legislature to do right by us all.

I thank you for your time, I really do. Let's help Minister Hoskins and Deputy Minister Bell keep their word.

M^me^ France Gélinas: Very good. You're preaching to the choir. I agree with you 100%.

The only part I'd like you to clarify is, if you had a choice between putting health care under the existing Ombudsman or keeping it under the Patient Ombudsman that has no teeth, what would you choose?

Mr. Gerald Parker: It's a really tough choice and it shouldn't be one or the other. Being a Patient Ombudsman is a very important job. They need the best CSI unit in the province. So can the Ombudsman, en général, do that themselves? Well, they're under-resourced and overwhelmed right now. Asking them to be CSI and medical examiners is not going to get the job done.

In answer to your question, the preference is to enable the Patient Ombudsman to be specialized, resourced, funded and factored, with expertise that the Ombudsman cannot provide at this time. If the Ombudsman is going to be provided with that resource as a quid pro quo, so be it. But my point is, we need the expertise, the funding and the factoring. That's the result that we need. How we get there is for you folks to figure out. And I want to trust you in doing that with my heart and with my family's very being.

M^me^ France Gélinas: In every other province and territory, their ombudsman is responsible for the health care system. We're the only one that has a Patient Ombudsman, with no teeth.

The Chair (Mr. Monte McNaughton): Madame Gélinas, that's all the time we have.

We'll move to the government now. Mr. Fraser.

Mr. John Fraser: Thank you very much for your presentation and for your work. I want to start out by saying that I understand that there are real challenges in the health care system, especially around transitions. I think that's where we have things happen, not with the frequency that might be implied by your remarks—because they are very concerning—but they happen more often than we want.

I understand what you're saying about the Patient Ombudsman. I do believe that she has enough teeth right now to impact individual patient cases, that she will, through HQO—HQO is an agency that is a part of the government, but it does deliver direct information that talks about the state of quality in our system. Maybe somewhere down the road it's appropriate to take a look at maybe the Patient Ombudsman should be inside the Ombudsman's office. I don't know. I think it's a bit early to tell.

I've seen some of your material around transitions, the thing that you're striving for in the system. I think it's critical that we recognize that there are some pretty serious challenges with transitions, which can do harm.

Mr. Gerald Parker: Thank you, MPP Fraser. The challenges of transitions—I'm not sure what that means. Maybe you could follow up—

Mr. John Fraser: Sorry, from setting to setting—in other words, you go from one provider to the next. So you're getting referred to a specialist, but that transition doesn't happen; or you're going from hospital to home or hospital back to long-term care. You were talking about people sliding between the cracks? That's what I'm—

The Chair (Mr. Monte McNaughton): Mr. Fraser? Sorry, that's all the time for the government's questions.

We're going to move to the official opposition. Mr. Bailey.

Mr. Robert Bailey: No, it's all right. I'll defer to Mr. Yurek.

Mr. Jeff Yurek: Thanks for coming in. Just back on the ombudsman, we had Christine Elliott here, who's an excellent Patient Ombudsman—being our first—but I know her personally. She's quite an excellent lady. She stated: "The perceived and actual independence of the Patient Ombudsman, an employee of Health Quality Ontario and whose staff are also employees of Health Quality Ontario, is at risk because of the potential conflict of interest that arises from having members of Health Quality Ontario staff, the Ontario Health Quality Council board and various Health Quality Ontario committees who are affiliated with or employed by health sector organizations...."

So it's not just the fact that, as the government says, she has enough teeth to do it; there is an apparent conflict of interest with her not being independent. Did you want to focus on that?

Mr. Gerald Parker: I agree with you. To go back to the point that I was trying to make about Health Quality Ontario and Patients First: I've had the conversation with ADM Naylor and her officers, and Josh Tepper, as I was asked by Deputy Minister Bell to follow up post that conference and its focus upon Patients First and the inherent conflict that that has. It's really hard, sometimes. Your dog has to bark at your neighbour, and if the dog's chained up and the neighbour's a bad guy and spending your money—I say "your money"—every time they do bad things, we need to enable that person to have that non-conflict of interest. We need to have someone stand up and actually advocate in a timely fashion. I can say this personally and also as a caregiver.

At your hardest, toughest hour, at your eleventh hour, your hour of desperation, you need help now, not nine months down the road. You don't want to have these

inter-agency turf fights, which happen. So the inherent conflict that comes with being under the purview of the minister, the unfortunate circumstances that that creates—

The Chair (Mr. Monte McNaughton): Mr. Parker, that's all the time. Thank you very much for your presentation today. We appreciate it.

To all the committee members, we'll be meeting Wednesday at 1 p.m. for continuation of public hearings. There's a deadline for amendments: Monday, November 28, at 5 p.m.

With that, we're adjourned until Wednesday at 1.

The committee adjourned at 1952.

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